03-69 s/a 02-1826, 02-1845 & 03-83

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IN THE

Supreme Court of the United States

VYTRA HEALTHCARE AND BRENT SPEARS, M.D.,

Petitioners,

v.

BONNIE CICIO,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, preempts state law claims that challenge a non-treating physician's alleged medical judgment in determining eligibility for coverage under an employee benefit plan?

PARTIES TO THE PROCEEDING

Petitioners are (1) Vytra Health Plans Long Island, Inc., a not-for-profit independent practice association model Health Maintenance Organization, which is controlled by and affiliated with Health Insurance Plan of Greater New York, Inc., a New York not-for-profit corporation, and (2) Brent Spears, M.D., who at all applicable times was the medical director of Vytra Health Plans. Respondent is Bonnie Cicio, acting individually and as administratrix of the estate of Carmine Cicio.

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JURISDICTION

The district court exercised jurisdiction over the plaintiff's claims under 28 U.S.C. § 1331, the complete preemption brought about by 29 U.S.C. § 1132, and the supplemental jurisdiction provision, 28 U.S.C. § 1367(a). The court of appeals asserted jurisdiction pursuant to 28 U.S.C. § 1291, and entered judgment on February 11, 2003. The court of appeals subsequently denied a timely-filed petition for rehearing and for rehearing *en banc* on April 21, 2003. Pet. App. 71a-72a. Jurisdiction in this Court exists under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution, U.S. Const. art. VI, cl. 2, provides in pertinent part:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the contrary notwithstanding.

Section 502(a) of ERISA, 29 U.S.C. § 1132(a) states in pertinent part:

> (a) Persons empowered to bring a civil action. A civil action may be brought (1) by a participant or beneficiary (A) for the relief provided in sub-section (c) of this section, or (B) to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . . .

Section 514(a) of ERISA, 29 U.S.C. § 1144(a), states as follows:

> (a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

STATEMENT

This case squarely presents a recurring federal question that is dividing and confusing the lower courts—namely, whether ERISA preempts state law claims that challenge a medical judgment made in connection with a benefit eligibility determination by a non-treating physician. This important question deserves this Court's immediate attention.

1. In 1974, after a decade of study, Congress enacted ERISA, a declared policy of which is to protect participants in employee benefit plans "by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b), (c). ERISA generally leaves to plan sponsors the decision whether to establish a benefit plan and, if so, the substantive terms of such a plan. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 512-13 (1981). But once an employer decides to establish a plan, ERISA imposes requirements for reporting and disclosure relating to such plans. 29 U.S.C. §§ 1021-1031. It also establishes certain standards of conduct for fiduciaries of employee benefit plans. *Id.* §§ 1101-1114. And it establishes comprehensive rules for the administration and enforcement of employee rights in such plans. *Id.* §§ 1131-1145.

As part of this scheme, § 502(a) of ERISA authorizes a participant, beneficiary, or fiduciary to bring suit "to recover benefits due to him under the terms of his plan, to enforce his

rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan" or generally "to enjoin any act or practice which violates any provision of [Title I of ERISA] or the terms of the plan." 29 U.S.C. §§ 1132(a)(1)(B), (3). Section 502 also confers exclusive federal jurisdiction over such suits. 29 U.S.C. § 1132(e)(1).

ERISA further provides in § 514(a) that, except where expressly noted otherwise, "the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any [covered] employee benefit plan . . . ." 29 U.S.C. § 1144(a). The principal goal of § 514(a) is "to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987).

In light of ERISA's uniformity goal, this Court has recognized that state laws can be preempted by ERISA in at least two ways. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138-44 (1990) (discussing ERISA's preemptive scope). *First*, § 502(a) completely preempts state law causes of action that add to or alter the remedies created under that section. *See id.* at 144-45; *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 377-81 (2002). *Second*, under § 514(a) of ERISA, state laws that "refer to" or have a "connection with" an employee benefit plan are also preempted. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987).

2. Petitioner Vytra Health Plans Long Island, Inc. ("Vytra"), is a Health Maintenance Organization ("HMO") that administers healthcare benefits to subscribers. Vytra contracts with employers to provide these benefits under an "Agreement for Comprehensive Health Services" (the "Plan"), an "employee benefit plan" within the meaning of ERISA, *see* 29 U.S.C. § 1002(3). Pet. App. 3a.

Respondent Bonnie Cicio ("Cicio") and her late husband Carmine Cicio received benefits under the Plan through Cicio's employer, North Fork Bank. As part of the Plan, the Cicios were entitled to "diagnosis and treatment of disease, injury or other conditions." *Id.* (quoting Plan Art. III, § 3.1(b)).

Vytra was not, however, required under the Plan to provide medical services unless they were medically "necessary." *Id.*; *see also id.* at 78a (Plan Art. III, § 3.5(a)) ("Vytra shall provide only Medically Necessary Vytra Services."). Vytra also was not required to provide "'[a]ny procedure or service which, in the judgment of Vytra's Medical Director, is experimental or is not generally recognized to be effective for a particular condition, diagnosis, or body area.'" *Id.* at 4a (quoting Plan Art. IX, § 9.3(f)).

In March 1997, Mr. Cicio was diagnosed with multiple myeloma, a form of blood cancer. Pet. App. 2a. After one type of chemotherapy failed, Mr. Cicio's then-treating oncologist, Dr. Edward Samuel, wrote Vytra "request[ing] insurance approval for treatment of Mr. Cicio with high dose chemotherapy supported with peripheral blood stem cell transplantation, in a tandem double transplant, for a diagnosis of multiple myeloma." *Id.* at 4a (citing Letter from Edward T. Samuel to Vytra dated January 28, 1998, at 1). Vytra's medical director, Dr. Brent Spears, denied Dr. Samuel's request. *Id.* Dr. Spears explained that the proposed procedure was "not a covered benefit according to this member's plan which states [that] experimental/investigational procedures are not covered." *Id.* (citing Letter from Brent W. Spears to Edward T. Samuel dated February 23, 1998, at 1).

Dr. Samuel wrote again to Dr. Spears, arguing that double or single stem transplants are promising treatments for multiple myeloma. Pet. App. 5a. Dr. Spears responded that a single stem cell transplant for Mr. Cicio would be covered by the Plan, but again denied coverage for a tandem stem cell

transplant. *Id.* (citing Letter from Brent W. Spears to Edward T. Samuel dated March 25, 1998, at 1). According to the Complaint, Mr. Cicio was, by that time, no longer a candidate for a double stem cell transplant and died on May 11, 1998. *Id.* (citing Compl. ¶ 31).

3. Respondent Cicio subsequently filed a complaint, on behalf of herself and the estate of her late husband in the New York State Supreme Court. Pet. App. 6a. The Complaint alleges eighteen state law causes of action based on Dr. Spears' conclusion that tandem stem cell transplants are experimental and thus not covered under the Plan. *Id.*

On May 30, 2000, Vytra and Dr. Spears (hereinafter, collectively "Vytra") removed the proceedings to the United States District Court for the Eastern District of New York. *Id.* On June 21, 2000, Vytra moved to dismiss the complaint for failure to state a claim. *Id.*

The motion was referred to Magistrate Judge E. Thomas Boyle, who found that the court had removal jurisdiction and that Vytra's Rule 12(b)(6) motion should be granted. Pet. App. 53a-70a. In relevant part, Judge Boyle reasoned that Cicio's state law claims were preempted under §§ 502(a) and 514(a) of ERISA, 29 U.S.C. §§ 1132(a)(1)(B), 1144(a), because "Vytra functioned solely as a plan administrator and bore no responsibility as a provider of medical services . . . . For this reason, the challenge here does not target the quality of care but rather attacks the benefits decision that was made." Pet. App. 67a.

The district court adopted the report and recommendation in full. *Id.* at 45a-52a. The court agreed that the Plan was an "employee benefit plan" under ERISA and thus subject to its requirements. *Id.* at 48a. In addition, the court agreed that Cicio's claims could not escape preemption simply because they arose from an eligibility determination involving medical judgment. *Id.* at 50a-51a.

4. In a divided decision, the Second Circuit reversed in part. Pet. App. 1a-44a. While the court affirmed the dismissal of most of Cicio's claims, it held that Cicio's medical malpractice claims were not preempted. *Id.* at 31a-36a.

a. With respect to the malpractice claims, the court found that such claims were different from the other claims asserted in Cicio's Complaint, because they involved Vytra's exercise of medical judgment, namely its decision that the treatment proposed by Dr. Samuel was experimental. *Id.* at 30a-31a. According to the Second Circuit, ERISA does not preempt such a traditional area of state law, even where mere coverage determinations are at issue. *Id.* at 31a-33a.

The Second Circuit based its holding on *Pegram v. Herdrich*, 530 U.S. 211 (2000). Although the Second Circuit recognized that *Pegram* was not an ERISA preemption case but concerned "only whether an HMO had . . . breached its fiduciary duty to members" (Pet. App. 28a), the court concluded that *Pegram* was nonetheless determinative:

> [*Pegram*] suggests that . . . some [healthcare] decisions involve interpretation of a benefits contract, eligibility decisions, and some involve application of medical judgment to a particular patient's condition, treatment decisions. And these two categories overlap. The resulting third category, described in *Pegram*, of "mixed eligibility and treatment decisions," is not limited to decisions made by treating physicians . . . who both assess which benefits a plan provides and make treatment decisions . . . . [E]ven if a physician does not directly control, direct, or influence a plaintiff's treatment, and even if the sole consequence of a physician's decision is reimbursement or its denial, that decision may nonetheless be a mixed eligibility and treatment decision.

Id. at 29a-30a (internal citations omitted).

In light of *Pegram*, the Second Circuit found that a "categorical distinction between 'quality of care' decisions and 'benefits administration' questions . . . . is no longer tenable." *Id.* at 31a-32a. Rather, *Pegram* "strongly suggests" that mixed eligibility determinations are not preempted and "that a defendant can no longer simply point to the overlay of medical decision-making on contractual claims and ask the Court to conclude that, because ERISA preempts the contract claims, it also preempts all state tort-law claims based on the same decision." *Id.* at 32a. Based on *Pegram*, the court held that Dr. Spears' denial "must be treated as a mixed decision because it allegedly involved both an exercise of medical judgment and an element of contract interpretation," and thus claims based on his decision were not preempted. *Id.* at 31a.

The Second Circuit recognized that "[o]ther courts addressing similar facts have concluded that malpractice claims based on utilization review decisions are indeed preempted by § 514." Pet. App. 26a (citing *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1326 (5th Cir. 1992), *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1488 (7th Cir. 1996), and *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995)). In the Second Circuit's view, these decisions were no longer persuasive because they "were decided before the Supreme Court's recent retrenchment of ERISA's preemption's margins, and before the Court, in its unanimous decision in *Pegram v. Herdrich*, addressed (albeit in *dicta*) medical malpractice actions against those engaged in medical decision making." *Id.* at 27a. The Second Circuit also recognized that its decision conflicted with the post-*Pegram* decision in *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 273 (3d Cir. 2001). Pet. App. 31a. But the court "decline[d] to adopt the categorical distinction between 'quality of care' decisions and 'benefits administration' questions applied by" the Third Circuit in that case. *Id.* In the Second Circuit's view, "*Pegram* teaches that this dichotomy is no longer tenable." *Id.* at 32a.

b. Judge Calabresi dissented. Pet. App. 37a-44a. In his view, "the majority's holding [could not be reconciled] with the Supreme Court's precedents and with the structure of ERISA itself, given those precedents." *Id.* at 38a. He reasoned:

> On these facts it seems to me clear beyond peradventure a) that the plan administrators were not, in any way, acting as Mr. Cicio's doctors, b) that what they were doing was—perhaps negligently—determining the scope and coverage of an ERISA-plan contract, c) that as a result of that allegedly improper denial of coverage, Mr. Cicio was financially unable to obtain, in time, the treatment he and his treating physician continued to seek, and d) that catastrophic, consequential damages—Mr. Cicio's death—flowed from the improper misreading of the ERISA-plan coverage. Mrs. Cicio then sued for those damages. If this is not a paradigmatic suit to remedy the violation of rights under the terms of the plan, I don't know what is.

Id. at 42a-43a. Judge Calabresi added that the majority made too "much of the fact that the coverage decision was erroneously made because of a *medical error* on the plan administrator's part. That may well be, but that fact seems to me irrelevant." *Id.* at 43a (emphasis in original).

With respect to *Pegram*, Judge Calabresi argued that the Court's *dicta* about preemption could "only make sense where the underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or such a physician's employer, as was the case in *Pegram*." *Id.* at 43a-44a. But "[w]here, as here, no such relationship exist[s], there is no apparent reason, in state or federal law, for treating the unlawful coverage decision any differently from any other unlawful coverage decision that is *not* based on medical error." *Id.* at 44a (emphasis in original).

5. On April 21, 2003, the Second Circuit denied a timely-filed petition for rehearing and rehearing *en banc*. Pet. App. 71a-72a.

REASONS FOR GRANTING THE WRIT

Every day, administrators of employee benefit plans, including non-treating physicians, make judgments about whether a proposed treatment is eligible for coverage under a benefit plan. Many of these judgments involve medical or clinical considerations, as benefit plans usually cover, for example, only "medically necessary" procedures and frequently exclude "experimental" treatments.

In *Pegram*, this Court considered whether medically-based coverage determinations, when made by a treating physician, are fiduciary acts under ERISA and held that such "mixed eligibility" decisions are not fiduciary acts. In doing so, the Court noted in *dicta* that its holding avoided "a puzzling issue of preemption"—to wit, whether applying federal fiduciary law to "mixed eligibility" decisions would preempt state medical malpractice challenges. *Pegram*, 530 U.S. at 236.

Since *Pegram* was decided, both the Executive Branch and numerous circuit courts and state courts of last resort have struggled to resolve a distinct but related preemption question under ERISA—namely, whether ERISA preempts state law claims challenging a non-treating physician's alleged medical judgment in determining eligibility for coverage under an employee benefit plan. The Executive Branch has argued to this Court that such state law causes of action should be preempted. But the lower courts have split into at least four different camps on the issue, and the jurisprudence in this area has become hopelessly confused. Seizing upon the *dicta* in *Pegram*, the Second Circuit and one state court of last resort have held that ERISA does not preempt state law claims challenging a non-treating physician's alleged medical judgment made in determining eligibility for coverage. In contrast, four other federal circuit courts—the Third, Fourth,

Sixth, and Eighth—have held these causes of action preempted under §§ 502(a) and 514(a) of ERISA. The Fifth Circuit has held that alleged medically-based eligibility determinations do not fall within the scope of § 502(a) of ERISA but are preempted under § 514(a). Finally, the Maryland Court of Appeals has held that ERISA preempts state law claims that challenge eligibility decisions unless a traditional medical malpractice action is involved.

This Court should clarify this confusion. The preemption issue dividing the courts is of vital importance. In addition, allowing the confusion to remain is contrary to ERISA's own expressed interest in uniform national rules for benefit plans. Finally, as Judge Calabresi argued in dissent below, the Second Circuit's view of this ERISA preemption question cannot be squared with this "Court's precedents and with the structure of ERISA itself . . . ." Pet. App. 38a.

I. THE DECISION BELOW ADDS TO THE CONSIDERABLE CONFUSION IN THE LOWER COURTS ABOUT WHETHER, AFTER *PEGRAM*, ERISA PREEMPTS STATE LAW CLAIMS INVOLVING ALLEGED MEDICALLY-BASED ELIGIBILITY DETERMINATIONS.

Prior to *Pegram*, at least seven federal courts of appeal—the First, Fifth, Sixth, Seventh, Eighth, Ninth, and Tenth Circuits—had concluded that state law claims challenging alleged medically-based eligibility determinations are preempted by ERISA. *See Turner v. Fallon Community Health Plan, Inc.*, 127 F.3d 196, 199-200 (1st Cir. 1997) (denial of breast cancer treatment on ground that it was experimental was not actionable in light of ERISA preemption); *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1, 5-7 (1st Cir. 1999) ("Although we recognize that the allegedly negligent decision making and consultation at issue here may be characterized as medical in nature, this fact alone does not remove the state causes of action from the scope of

§ 502(a)."); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1332 (5th Cir. 1992) (state law claims based on denial of hospitalization benefits as medically unnecessary not actionable because a benefit plan administrator "makes medical decisions as part and parcel of its mandate to decide what benefits are available."); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 942-43 (6th Cir. 1995) (claims based on denial of hospitalization as medically unnecessary preempted by ERISA); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1493 (7th Cir. 1996) (alleged failure to treat preempted as related to eligibility decision); *Thompson v. Gencare Health Sys., Inc.*, 202 F.3d 1072, 1073-74 (8th Cir. 2000) (refusal to extend benefits for breast cancer treatment as medically unnecessary was not actionable under medical malpractice law); *Kuhl v. Lincoln Nat'l Health Plan of Kan. City, Inc.*, 999 F.2d 298 (8th Cir. 1993) (state law claims based on delay in approving heart surgery preempted); *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1008 (9th Cir. 1998) (no state law claim allowed for breast cancer treatment denied as experimental); *Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270, 1273-74 (10th Cir. 1996) (decision to deny leukemia treatment as experimental could not be the basis of state law claims because claims were preempted by ERISA). Three circuits had, indeed, rejected state law claims based on the exact factual scenario here—specifically, an allegation that a non-treating physician was negligent in denying coverage for some proposed medical treatment as experimental. *Bast*, 150 F.3d at 1008; *Turner*, 127 F.3d at 199-200; *Cannon*, 77 F.3d at 1273-74.

This widespread judicial consensus quickly eroded in the wake of this Court's decision in *Pegram*. Since June 2000, at least six federal circuit courts and two state courts of last resort have considered whether state law claims challenging alleged medically-based eligibility determinations are preempted by ERISA, and they have rendered conflicting decisions based on four different, inconsistent rationales.

Some courts have held that state law claims concerning alleged medically-based eligibility determinations are not preempted at all, under any provision of ERISA. Others, however, have held that such claims are completely preempted under §§ 502(a) and 514(a) of ERISA. Still another court has held that, while state law claims are not within the scope of § 502(a), they are preempted under § 514(a). Finally, one court has held that ERISA preempts state law claims except insofar as a traditional malpractice claim is involved.

In the first camp, the Pennsylvania Supreme Court has joined the Second Circuit and held that alleged medically-based eligibility determinations are not preempted by any provision of ERISA. *See Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001), *cert. denied sub nom. U.S. Healthcare Sys. of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 536 U.S. 938 (2002). Like the Second Circuit, the Pennsylvania Supreme Court concluded that *Pegram* instructs that a "mixed eligibility and treatment decision implicates a state law claim for medical malpractice, not an ERISA cause of action for fiduciary breach. Thus if [plaintiff's] third party claim against [the benefit plan administrator] arose out of a mixed decision, it is, according to *Pegram*, subject to state medical malpractice law." *Pappas*, 768 A.2d. at 1095; *see also id.* at 1096 ("His was a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed, as *Pegram* teaches, through state medical malpractice law. This law . . . is not preempted by ERISA."). *See also Villazon v. Prudential Health Care Plan, Inc.*, 843 So. 2d 842, 850-51 (Fla. 2003) (although not deciding preemption question here, observing that *Cicio* decision "is consistent with and reflective of the current state of the law in Florida" and that it will apply in future preemption cases "the analysis employed in . . . *Pappas*.").

In contrast, the Third, Fourth and Sixth Circuits have held that state law claims challenging alleged medically-based eligibility determinations are preempted by both §§ 502(a) and

514(a) of ERISA. The Eighth Circuit has indicated that it is in this camp as well.

In *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), a post-*Pegram* decision that the Second Circuit expressly acknowledged conflicts with its own (Pet. App. 31a), the Third Circuit held that a state law claim seeking damages for a denial of coverage was completely preempted by ERISA. The court acknowledged that *Pegram* "suggests preferable terminology" for courts to use when analyzing ERISA claims, but concluded that *Pegram* ultimately does not alter preemption analysis:

> [r]egardless of the language used, the ultimate distinction to make for purposes of complete preemption is whether the claim challenges the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted, or the quality of the medical treatment performed, which may be the subject of a state action.

Id. at 273. Accordingly, the court reaffirmed its pre-*Pegram* preemption decisions, *see id.* (citing *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 356 (3d Cir. 1995)), and held that "a claim alleging that an HMO declined to approve certain requested medical services or treatment on the ground that they were not covered under the plan would manifestly be one regarding the proper administration of benefits. Such a claim, no matter how couched, is completely preempted and removable on that basis." *Id.*

Similarly, in *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003), the Fourth Circuit held that state law claims challenging alleged medically-based eligibility determinations are completely preempted by ERISA. It, too, rejected the argument that *Pegram* should be read to alter ERISA's preemption analysis:

> [E]ven though the distinction between pure eligibility decisions and treatment decisions may tend to blur when the treating physician is also responsible for making eligibility decisions . . . that is not the case here where the treating physicians and [benefits administrator] were institutionally segregated from one another. [The administrator] worked for an independent utilization review agent that was under contract with [a preferred provider network] . . . and the treating physicians were simply employed by, or connected with, the hospital to which [the insured] was admitted. Under this arrangement, treatment decisions and eligibility decisions were made by different people at different times according to different policies."

Id. at 326. The Fourth Circuit concluded that the plaintiffs could not "transform what is properly considered a § 502(a) claim into a state-law claim for malpractice simply by making unsubstantiated and incorrect statements that an independent utilization review agent was responsible for medical decisions." *Id.* at 326-37.

The Sixth Circuit has also reaffirmed, since *Pegram* was decided, its earlier decisions holding state law actions arising from medically-based eligibility determinations preempted. Specifically, in *Caffey v. Unum Life Ins. Co.*, 302 F.3d 576, 582 (6th Cir. 2002), the Sixth Circuit considered a state law claim arising from a benefit administrator's decision that a proposed medical treatment was not covered, in part, because the treating physician's diagnosis was incorrect. *Id.* at 579. The court concluded that the claim was preempted because "[a]ll of plaintiff's state-law claims stem from the actions of [the administrator] in the processing of her claim for benefits." *Id.* at 582. Although the court did not specifically discuss *Pegram*, it concluded that its view of ERISA preemption was compelled by this Court's jurisprudence. *See id.*

The Eighth Circuit has also strongly indicated in a pair of cases that state law claims challenging alleged medically-

based eligibility determinations are preempted. Prior to *Pegram*, in *Thompson v. Gencare Health-Systems, Inc.*, 202 F.3d 1072, 1073 (8th Cir. 2000), the court rejected the argument that a plaintiff's medical malpractice claim was not preempted because it implicated a medical judgment, reasoning that the plaintiff "and her treating physicians retained the ultimate decision-making authority regarding her medical care." *Id.* at 1074. Subsequently, in *Howard v. Coventry Health Care of Iowa, Inc.*, 293 F.3d 442 (8th Cir. 2002), the court refused to modify its ERISA preemption analysis in light of *Pegram*:

> *Pegram* addresses an issue not before this court: ERISA actions in the context of claims for breach of duties by plan fiduciaries. Moreover, *Pegram* did not hold that all quality of care claims exist outside the scope of ERISA or support [plaintiff's] contention of a cause of action outside of ERISA. Thus, *Pegram* does not support [plaintiff's] claim.

Id. at 445 (internal citations omitted).

In contrast to these courts, the Fifth Circuit has concluded that state law challenges to alleged medically-based eligibility determinations are *not* preempted under § 502(a) of ERISA but are subject to § 514(a) preemption. In *Roark v. Humana, Inc.*, 307 F.3d 298, 315 (5th Cir. 2002), *petition for cert. filed*, 71 U.S.L.W. 3791 (U.S. June 3, 2003) (No. 02-1826), and *petition for cert. filed sub nom. Aetna Health Inc. v. Davila*, -- U.S.L.W. -- (U.S. June 20, 2003) (No. 02-1845), the Fifth Circuit considered four consolidated appeals, all of which involved coverage claims asserting delay or refusal of physician-recommended treatment. The court reasoned that *Pegram* altered the analysis of complete preemption under § 502(a) of ERISA such that an eligibility determination involving a medical judgment by a non-treating physician was not completely preempted by that section of ERISA. *Id.* at 307-08. In the court's view, *Pegram* suggested that § 502(a) was not intended to federalize medical malpractice law, and

claims challenging medically-based eligibility determinations are such malpractice challenges. *Id.* at 308-11. With respect to preemption under § 514 of ERISA, however, the court concluded that *Pegram* could *not* be read to overrule the Fifth Circuit's earlier decisions holding that claims involving alleged medically-based eligibility determinations are preempted by this provision of ERISA. *Id.* (citing *Corcoran*, 965 F.2d at 1332-34). An *en banc* panel of the Fifth Circuit subsequently declined to rehear the case *en banc* or revisit its earlier § 514 precedent. *See also Haynes v. Prudential Health Care*, 313 F.3d 330, 336 (5th Cir. 2002) ("[W]e do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment.").

The final approach to preemption was announced by the Maryland Court of Appeals in *Eid v. Duke*, 816 A.2d 844 (Md. 2003). Without specifying the particular source of ERISA preemption, the court held that a cause of action challenging an alleged medically-based eligibility determination is preempted unless it states a claim under traditional malpractice law. In the Maryland Court of Appeals' view, *Pegram* means that:

> [T]he issue of preemption is inextricably bound up with the availability of a traditional medical malpractice claim under state law. If the nature of the action constitutes a traditional state law medical malpractice action, it is probably not preempted by ERISA. If, however, a physician's decision would not give rise to a traditional medical malpractice action, but is entirely an administrative decision concerning eligibility under or coverage of an ERISA plan, it is preempted.

Id. at 852. Applying this rule, the court held that the action before it—which involved a determination that the plaintiff was not disabled, *see id.* at 847-48—was preempted, because Maryland malpractice law required a "relationship of doctor

and patient as a result of a contract . . . that the doctor will treat the patient." *Id.* at 852. But the plaintiff had no such relationship with the benefits administrator; rather, the administrator "was acting entirely within his capacity as a fiduciary under the Plan." *Id.* at 853.

The conflict does not end with the lower courts, as the United States has also published its views on the preemption issue in a brief submitted to this Court. Specifically, in its *amicus* brief signed by the Solicitor General and the Solicitor of the Department of Labor and filed in *Rush Prudential HMO, Inc. v. Moran*, No. 00-1021, 2001 WL 1480556 (filed Nov. 7, 2001), the United States argued that state law challenges to eligibility decisions under benefit plans should be preempted "even if the subject of the decision is 'medical necessity' and the decisionmaker is a physician." *Id.* at *10; *see also id.* at *8-9 (discussing *Pegram*). With regard to *Pegram*, the United States stated that:

> Some statements in *Pegram*, if read in isolation, might suggest that such "mixed decisions" . . . are never fiduciary acts under ERISA, regardless of whether they are made by the treating physician or by another physician who is ruling on a beneficiary's internal appeal of the denial of her claim. If so, there might then be a question whether a state law governing mixed decisions "relates to" ERISA plans at all. The better reading of *Pegram*, however, is that it addresses only mixed decisions made by treating physicians. *Pegram* grew out of such a decision by the plaintiff's treating physician.

Id. at 8.

Not surprisingly, much has already been written about the confusion and conflict that has arisen in *Pegram*'s wake. Discussing this case, Carter Phillips has called ERISA "a nightmare," and its preemption provision "largely imponderable." David Hechler, *After ERISA Decision, Confusion Remains*, N.Y.L.J., Mar. 6, 2003, at 5 (quoting

Carter Phillips). Other practitioners have offered that "[t]he bottom line is the courts are split on this issue about how to read *Pegram*, and whether there is pre-emption where there is a mixed medical and eligibility decision." Judy Greenwald, *Court may revisit* Pegram*; Interpretations muddy waters on HMO ruling*, BUS. INS. at 1 (Oct. 8, 2001).

This conflict, moreover, will not resolve itself over time but will worsen. There is no reason to expect that the Second Circuit will reconsider its *Cicio* decision. The court denied a motion to rehear the case *en banc* despite Judge Calabresi's dissenting vote, and the court has since cited *Cicio* as settled circuit precedent. *See Gerosa v. Savasta & Co.*, 329 F.3d 317, 326 n.7 (2d Cir. 2003); *Rubin-Schneiderman v. Merit Behavioral Care Corp.*, 60 Fed. Appx. 887, 887 (2d Cir. Apr. 18, 2003) (remanding to district court in light of *Cicio*). Courts on the other side of the preemption issue, moreover, have expressly rejected the Second Circuit's reasoning. *See, e.g.*, *Pryzbowski*, 245 F.3d at 274-75; *Haynes*, 313 F.3d at 536. So has the United States in its *amicus* brief in *Rush*. In short, even though *Pegram* was decided just a few years ago, its *dicta* has already deeply divided and confused the lower courts, and the arguments on every side of the issue have been well ventilated. This Court's immediate review of the preemption issue is thus necessary and appropriate.

II. THE QUESTION PRESENTED IS A RECURRING ONE OF NATIONAL IMPORTANCE THAT REQUIRES IMMEDIATE RESOLUTION.

Beyond implicating a split of authority, the question presented is one of national importance that arises with great frequency. Failure to resolve the issue promptly will undermine the uniformity objective of ERISA, waste substantial judicial resources, and have a deleterious impact on health care coverage.

There can be no serious debate that ERISA preemption questions have great national importance. This Court has

characterized the policy underlying ERISA preemption—"uniform national treatment" of benefits—as one of great importance. *See Patterson v. Shumate*, 504 U.S. 753, 765 (1992). Indeed, the Court has recognized that "ERISA pre-emption questions are recurrent" precisely because of "the comprehensive nature of the statute, the centrality of pension and welfare plans in the national economy, and their importance to the financial security of the Nation's work force." *Boggs v. Boggs*, 520 U.S. 833, 839 (1997).

The particular preemption question presented here—whether state law claims challenging alleged medically-based eligibility determinations are preempted—is especially important, because so many coverage decisions involve medical determinations. *See* R. Rosenblatt, *et al.*, LAW & THE AMERICAN HEALTH CARE SYSTEM 211-12, 568-70 (1997). For example, benefit administrators frequently make decisions about the efficacy of medical procedures, whether procedures are experimental and/or whether a procedure is medically necessary. *Id.* at 211-15. Moreover, because of the rate of technological change and scientific and medical experimentation, as well as the growth of healthcare fraud and unduly defensive medical practice, novel eligibility and coverage questions involving benefit provisions of this type arise with great frequency. *Id.* at 19, 212-13. Accordingly, the question presented here affects literally thousands of benefit plans and millions of healthcare decisions by benefit administrators. Indeed, in the three years since *Pegram* was decided, eight courts of appeal and state courts of last resort have already opined on this preemption question. And the same issue is pending in or has recently been decided by numerous district courts as well. *See Land v. Cigna Healthcare*, No. 02-15549EE (11th Cir. notice of appeal filed Oct. 7, 2002); *Waldschmidt v. Aetna U.S. Healthcare*, 225 F. Supp. 2d 560, 565-66 (W.D. Pa. 2002); *Isaac v. Seabury & Smith, Inc.*, No. IP0-1-C1437 B/S, 2002 WL 1461710, at *1 (S.D. Ind. July 5, 2002); *Tanous v. United Behavioral Health*,

No. 8:01CV297, 2002 WL 378508, at *1-*2 (D. Neb. Mar. 12, 2002); *Tran v. Kaiser Found. Health Plan of Tex.*, No. Civ.A. 300CV1559P, 2001 WL 1082418, at *6 (N.D. Tex. Sept. 7, 2001); *Schusteric v. United Healthcare Ins. Co. of Ill.*, No. 00 C 4156, 2000 WL 1263581, at *2 (N.D. Ill. Sept. 5, 2000); *Rivers v. Health Options Connect, Inc.*, 96 F. Supp. 2d 1370, 1373 (S.D. Fla. 2000).

For this reason, the Solicitor General in his petition-stage *amicus* brief in *Rush* characterized the preemption issue here as one "of very broad significance." *See Rush Prudential, Inc. v. Moran*, No. 00-1021 (Br. filed May 31, 2001). Consistent with this observation, in the court below, five national and state organizations—the American Medical Association, the American College of Legal Medicine, the Medical Society of the State of New York, the American Association of Health Plans, and the New York Health Plan Association—signed *amicus* briefs addressing this preemption question. Finally, both legal academics and national news commentators have opined on the importance of the issue:

> the significance of the holding by the Second Circuit cannot be overstated. Its broad interpretation of *Pegram* and its protection of state law causes of action regarding medical practice and health care are monumental.

Thomas A. Moore & Matthew Gaier, *Recent Second Circuit Decision on HMO Liability*, N.Y.L.J., Mar. 10, 2003, at 3; *see also* Roni Rabin, *HMO Can Be Sued*, NEWSDAY, Feb. 21, 2003, at A4 (calling *Cicio* a "significant" ruling that "touches on a key controversy"); Leo T. Crowley, *Door Opens for Malpractice Claims to Outlast Preemption Disputes*, N.Y.L.J., Mar. 6, 2003, at 3 (observing that *Cicio* decision "creates a huge gap in the once-formidable wall of ERISA preemption"); Robert Pear, *A Court Expands the Rights of Patients to Sue HMO's*, N.Y. TIMES, Feb. 18, 2003, at A14 (observing that decision greatly "expanded patients' rights"); M. Freudenheim, *A Court says Insurance Companies Should*

be Accountable for Damage to a Patient's Health, N.Y. TIMES, Feb. 20, 2003, at C7 (quoting Dr. Richard Corlin that "[*Cicio*] is a very important case in which the highest court in the country below the Supreme Court has completely pierced ERISA.").

The Court should not delay in resolving the issue and the conflict over it. Every day that the conflict is allowed to persist, ERISA's goal of "set[ting] forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans" is undermined. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). The state of the law in Pennsylvania amply demonstrates how harmful this disuniformity can be: In that State, citizens and health plans are subject to plainly inconsistent legal standards, depending upon whether they are in federal or state court. *Compare Pryzbowski*, 245 F.3d at 273 *with Pappas*, 768 A.2d at 1095. Moreover, the diversity in judicial opinion about this issue creates an incentive for forum shopping and for arbitrary legal results, since benefit plans cover employees who may work and/or reside in a multi-State area.

In addition, as this Court has recognized, continuing legal uncertainty harms plan participants by causing employers to reduce or eliminate coverage. *See Pilot Life*, 481 U.S. at 54; *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262-63 (1993). One expert in this field has explained (in discussing this precise preemption question) that "[a]ny increase in costs as well as the uncertainty that accompanies litigation will force employers to confront the costs associated with the potential for large damage awards or settlements, and would discourage them from including broad categories of coverage, or from even sponsoring coverage for their employees altogether." Stephanie Kanwit, *Should HMO Coverage Decisions be Subject to Medical Malpractice Lawsuits? No: It Makes No Sense*, THE REGULATOR, May 2003, at 12. Indeed, failing to

review the question presented now would waste tremendous private and judicial resources, as numerous district courts consider the same recurring issue and render deeply conflicted decisions.

This case is an excellent vehicle for the Court to use in resolving this ERISA preemption question. The court below considered and rejected ERISA preemption under *both* § 502(a) and § 514(a), thus allowing the Court to consider the entire preemption issue in a single case. Both the § 502(a) and § 514(a) questions were cleanly presented to the lower court, and there are no procedural or jurisdictional issues that might preclude the Court's review. Moreover, the Second Circuit expressly acknowledged the conflict in this area, and its decision was issued over a forceful and informative dissent by Judge Calabresi. In short, the time has come for the Court to resolve the ERISA preemption question presented, and this case is the proper medium through which to do so.

III. THE SECOND CIRCUIT ERRED IN CONCLUDING THAT CICIO'S CLAIM IS NOT PREEMPTED BY ERISA.

The Court should also be concerned to correct the error of the court below. The Second Circuit's holding that state law claims challenging alleged medically-based eligibility determinations are not preempted is, as Judge Calabresi argued, contrary to ERISA's structure and the overwhelming precedent of this Court.

First, the lower court's determination that these state law claims are not preempted under § 514(a) of ERISA is erroneous. Section 514(a) provides, in relevant part, that ERISA "shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan." 29 U.S.C. § 1144(a). A state law medical malpractice action challenging an eligibility determination, even one that involves medical judgment, is plainly such a law.

A benefit plan within the meaning of ERISA is "a set of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan." *Pegram*, 530 U.S. at 223. Moreover, this Court has said that a state law "relate[s] to" such a benefit plan if it "has a connection with or reference to [the] plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983). Under the latter inquiry, the Court has held preempted laws that "impos[e] requirements by reference to [ERISA] covered programs," *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130-31 (1992), and laws that establish the existence of an ERISA plan as the "critical factor in establishing liability under the State's [law]." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139-40 (1990). With respect to the former inquiry, this Court has suggested that it should be understood in a "broad sense." *Shaw*, 463 U.S. at 98. Of course, more recently, the Court has made clear "that an 'uncritical literalism' in applying this standard offer[s] scant utility in determining Congress' intent as to the extent of § 514(a)'s reach." *Calif. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997) (quoting *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995)). "Rather, to determine whether a state law has the forbidden connection, [the Court] look[s] both to 'the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive,' as well as to the nature of the effect of the state law on ERISA plans." *Id.* (quoting *Travelers*, 514 U.S. at 656) (internal citation omitted).

Regardless of the exact approach to § 514(a) preemption this Court has applied, it has *always* recognized that state law claims like the one asserted here—that directly implicate the construction and administration of the benefits plan—are

preempted. In *Shaw*, for example, the Court held that the New York Human Rights Law, which prohibited employers from establishing benefit plans that discriminated on the basis of pregnancy, was preempted because the law had the effect of "requir[ing] employers to pay employees specific benefits." *Shaw*, 463 U.S. at 97. In the first half of this Court's decision in *Pilot Life*, 481 U.S. at 48, the Court concluded that common law claims "based on alleged improper processing of a claim for benefits under an employee benefit plan, *undoubtedly* meet the criteria for pre-emption under § 514(a)." *Id.* (emphasis supplied). More recently, in *Rush*, the Court, considering a case involving whether a proposed treatment was "medically necessary," observed that a state law requiring independent review of disputes between HMOs and primary care physicians over the "medical necessity" of a treatment was "beyond serious dispute" a law that "relates to employee benefit plans within the meaning of [§ 514(a)]" because it required HMOs "to submit to an extra layer of review for certain benefit denials." 536 U.S. at 365.

The state law cause of action at issue here—a malpractice action challenging an alleged improper determination of whether a medical procedure was covered under an employee benefit plan—is no different in kind or degree from these preempted state laws. Like the common law claim at issue in *Pilot Life*, the claim here is based on an allegation that some alleged benefit was improperly denied. And Cicio's claim, like the Illinois law at issue in *Rush*, seeks to add another layer of review on top of benefit denials involving medical judgments, only this time the review sought is by a court rather than an arbitrator. Ultimately, the dispute here turns on the rules regarding "definition of benefits," which is part and parcel of a benefit plan. *Pegram*, 530 U.S. at 223.

There is, moreover, no exception to § 514(a) preemption applicable here that might save Cicio's claims from preemption. Unlike the law at issue in *Rush*, which this Court ultimately held was saved from preemption because it

regulated insurance, common law tort principles governing medical malpractice claims are not such insurance regulations. Indeed, this Court has repeatedly held that a "common law of general application . . . is not a law regulating insurance" within the meaning of ERISA's savings clause. *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 62 (1987); *see Pilot Life*, 481 U.S. at 51 (rejecting argument that state law bad faith claim was an insurance regulation because it "has developed from general principles of tort and contract law.").

Second, Cicio's claims are also preempted under § 502(a). This section provides a federal remedy for "a participant or beneficiary" of an employee benefit plan "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). As this Court has recognized, if an action under state law falls within § 502(a)'s scope, it is preempted to the extent the state law entitles a plan participant to remedies that are not provided for in § 502(a). *Rush*, 536 U.S. at 379 (observing that any law that "provided a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA . . . . patently violates ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct").

Clearly, state law claims, such as Cicio's, which allege that benefits were improperly denied as a result of a mistaken medical judgment by a non-treating physician, fall within the scope of § 502(a)(1)(B). Indeed, this case is little different from *Metropolitan Life*. In that case, this Court held that tort and contract law claims arising from an alleged improper determination that an employee was not disabled, and not entitled to disability benefits, fell "directly under § 502(a)(1)(B) of ERISA," because the suit was "by a beneficiary to recover benefits from a covered plan." 481 U.S. at 62-63. Cicio's claim is analytically indistinguishable.

In addition, the remedies that Cicio seeks, consequential and punitive damages in excess of $220 million, are not authorized under § 502(a). *See Mertens*, 508 U.S. at 261-63. Allowing Cicio's action to proceed would thus impermissibly alter the remedies provided under ERISA. As Judge Calabresi observed, the Supreme Court "has moved more and more in the direction of barring only those state actions which, if local law were permitted to govern, would expand (or contract) the relief available beyond that provided by § 502(a) of ERISA," but "[e]ven accepting this more limited . . . scope of preemption, where does that leave Mrs. Cicio's suit? . . . . I regretfully conclude that it is barred." Pet. App. 41a.

Third, the Second Circuit improperly read *Pegram* to save state law causes of action challenging alleged medically-based eligibility determinations. *Pegram* was not even an ERISA preemption case. The sole issue that *Pegram* addressed was whether a "mixed eligibility" decision was a fiduciary act under ERISA. Moreover, in *Pegram*, this fiduciary act question arose in a context where a *single* physician functioned both as the treating physician and as the administrator rendering eligibility determinations. *Pegram*, 530 U.S. at 237. This case, in contrast, asks whether ERISA preempts a state law action challenging an eligibility determination by a *non-treating* physician.

To be sure, there is (as Judge Calabresi characterized it) some "unexplained" and "well intentioned *dicta*" in *Pegram* (Pet. App. 43a) which could be read to suggest that, when a benefit plan administrator makes any sort of eligibility determination that requires medical judgment, it never acts as a fiduciary under ERISA. *See id.* at 231. But this is not, as the Solicitor General has argued, the proper way to read *Pegram*'s *dicta*. *Rush Prudential HMO, Inc. v. Moran*, No. 00-1021, 2001 WL 1480556, at *8 (filed Nov. 7, 2001) (emphasis supplied). *Id.* "The better reading of *Pegram*, . . . is that it addresses only mixed decisions *made by treating physicians*." *Id.* (emphasis added).

In any event, the Court's *dicta* in *Pegram* provides no guidance here. *Pegram*'s *dicta*, including its remarks about a "puzzling issue" of ERISA preemption, concerned whether application of ERISA's fiduciary duty provisions to "mixed eligibility" decisions would work a preemption of state malpractice claims. *See* 29 U.S.C. § 1109(a). Nothing in the opinion speaks to the distinct ERISA preemption question here—to wit, whether a challenge to a benefits coverage determination is preempted by the provisions of §§ 502 and 514 of ERISA that make enforcement of the terms of an employee benefit plan the exclusive province of federal law. *See id.* §§ 1132(a)(1)(B); 1144(a). Whether a "mixed eligibility" decision is a fiduciary act or not, a coverage determination is in all events a construction of the terms of a benefit plan within the scope of § 514(a) for which ERISA provides a direct cause of action under a provision of § 502—a cause of action that is separate from the statute's fiduciary duty and enforcement provisions. For this reason, *Pegram*'s *dicta* about the scope of fiduciary duties (and related preemption issues) is wholly inconclusive of the distinct ERISA preemption question presented here.

Of course, *Pegram*'s concern about not unnecessarily preempting state medical malpractice law is implicated here too. But there is no suggestion being made here that a state law challenge to a physician's *treatment* decision is preempted under ERISA. Rather, the suggestion made here is simply that *coverage* determinations themselves are at the heart of ERISA and that state law challenges to coverage decisions are preempted, whether they involve medical considerations or not. *Pegram*'s discussion of fiduciary duties and related preemption questions simply do not address, much less answer, this fundamentally different question.

CONCLUSION

For these reasons, the petition for a writ of *certiorari* should be granted.

Respectfully submitted,

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July 11, 2003

APPENDIX

321 F.3d 83

United States Court of Appeals,
Second Circuit.

Bonnie CICIO, individually and as Administratrix of the Estate of Carmine Cicio, Plaintiff-Appellant,

v.

John DOES 1-8, Defendants,
Vytra Healthcare, and Brent Spears, M.D.,
Defendants-Appellees.

Docket No. 01-9248.

Argued: June 20, 2002

Decided: Feb. 11, 2003.

As Amended: March 12, 2003.

Before: CALABRESI, SACK, and B.D. PARKER, Jr., Circuit Judges.

Judge CALABRESI dissents in part in a separate opinion.

SACK, Circuit Judge.

Plaintiff Bonnie Cicio appeals from an October 4, 2001 judgment of the United States District Court for the Eastern District of New York (Joanna Seybert, *Judge*) denying her motion to remand her action to New York Supreme Court, and granting the Fed. R. Civ. P. 12(b)(6) motion of the defendants Vytra Healthcare ("Vytra") and Dr. Brent Spears to dismiss the complaint for failure to state a claim upon which relief can be granted. *Cicio v. Vytra Healthcare*, 208 F. Supp. 2d 288, 293 (E.D.N.Y. 2001). The district court, adopting the March 13, 2001 report and recommendation of Magistrate Judge E. Thomas Boyle, *id.* at 293, held that all of the plaintiff's claims, which derive from the defendants-appellees' decision to deny the plaintiff's

deceased spouse, Carmine Cicio, preauthorization for a requested medical procedure, were preempted by the Employee Retirement Income Security Act of 1974, 88 Stat. 832, as amended, 29 U.S.C. § 1001 *et seq.* ("ERISA"). *Cicio*, 208 F. Supp. 2d at 293. The plaintiff now appeals on the sole ground that her claims are not preempted by ERISA.

We agree with the plaintiff that the district court erred in dismissing the medical malpractice claims at this stage of the proceedings. We conclude, however, that the district court correctly dismissed the plaintiff's claims that are based on the defendants' alleged misrepresentations or alleged negligence in delaying a coverage decision with respect to Mr. Cicio's medical care. Accordingly, we affirm in part and remand in part.

BACKGROUND

Carmine Cicio's Illness and Treatment

Because this case comes to us on appeal from the grant of a motion to discuss under Fed. R. Civ. P. 12(b)(6), we review the facts as they have been alleged by the plaintiff. *See, e.g., ICOM Holding, Inc. v. MCI Worldcom, Inc.*, 238 F.3d 219, 221 (2d Cir. 2001). In March 1997, the plaintiff's spouse, Carmine Cicio, was diagnosed with multiple myeloma.[1] He began chemotherapy the following month. At that time, both he and the plaintiff received health care benefits pursuant to an "Agreement for Comprehensive Health Services" (the "Plan") administered by Vytra, an "Individual Practice Association-Health Maintenance

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[1] "Multiple myeloma is the second most prevalent blood cancer and represents approximately 1% of all cancers and 2% of all cancer deaths." Multiple Myeloma Research Foundation, *The Statistics*, *at* http://www.multiplemyeloma.org/aboutmyeloma/statistics.html (last visited September 16, 2002).

Organization."[2] The plaintiff's employer, North Fork Bank, had purchased the Plan from Vytra. The Plan, it is now undisputed, is an "employee benefit plan," as defined in 29 U.S.C. § 1002(3) of ERISA.[3]

The Plan's subscriber agreement explains that Vytra provides Plan enrollees with, *inter alia*, "[d]iagnosis and treatment of disease, injury or other conditions." Agreement for Comprehensive Health Servs. Art. III, § 3.1(b). The Plan cautions, however, that "Vytra shall provide only Medically Necessary Vytra Services . . . ." *Id.* Art. III, § 3.5(a). Vytra

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[2] An independent practice association is a "local physician group . . . comprised of physicians who are active on [a] hospital's medical staff" and contract with a health maintenance organization to provide medical services. Kenneth R. Wing *et al.*, *The Law and American Health Care* 1005-06 (1998) (citing Carl H. Hitchner *et al.*, *Integrated Delivery Systems: A Survey of Organizational Models*, 29 WAKE FOREST L. REV. 273, 275 (1994)). Health Maintenance Organizations ("HMOs") are entities that "offer a form of health insurance [that differs from traditional medical insurance] . . . . HMOs are not guaranteeing to *reimburse* the insured for medical expenses; rather, their obligation to the insured is more direct—to actually *provide* medical services to them." *Id.* at 77 (internal citation omitted; emphasis in original); *see also Pegram v. Herdrich*, 530 U.S. 211 (2000) ("The defining feature of an HMO is receipt of a fixed fee for each patient enrolled under the terms of a contract to provide specified health care if needed.").

In an "Individual Practice Association-Health Maintenance Organization," "physicians' services are established with a relatively large number of generally small or medium-sized group practices, with physicians receiving some type of discounted fee-for-service payment from the HMO, rather than . . . . salaried reimbursement . . . ." *Id.* at 81 (internal citation omitted).

[3] A plan within the meaning of ERISA is "a set of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan." *Pegram*, 530 U.S. at 223. Here, the "Agreement for Comprehensive Health Services" fulfills that function.

also disclaims the obligation to provide "[a]ny procedure or service which, in the judgment of Vytra's Medical Director, is experimental or is not generally recognized to be effective for a particular condition, diagnosis, or body area . . . ." *Id.* Art. IX, § 9.3(f).

On January 28, 1998, some ten months after Carmine Cicio's disease was first diagnosed, his treating oncologist, Dr. Edward Samuel, wrote a detailed letter to Vytra "request[ing] insurance approval for treatment of Mr. Cicio with high dose chemotherapy supported with peripheral blood stem cell transplantation, in a tandem double transplant, for a diagnosis of multiple myeloma."[4] Letter from Edward T. Samuel to Vytra dated January 28, 1998, at 1. Dr. Samuel set forth Carmine Cicio's clinical history and prior treatments, including one type of chemotherapy that had failed, before explaining why "a change in strategy of treatment . . . had to be made." *Id.* And Dr. Samuel explained why he thought that Mr. Cicio was a good "candidate" for the transplant. *Id.* at 2.

Almost a month later, in a letter dated February 23, 1998, Vytra's medical director, the defendant Dr. Spears, denied Dr. Samuel's request, stating only that the procedure sought was "not a covered benefit according to this member's plan which states [that] experimental/investigational procedures are not covered." Letter from Brent W. Spears to Edward T. Samuel dated February 23, 1998, at 1. On March 4, after unsuccessful attempts to contact Dr. Spears by telephone,

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[4] A peripheral blood stem cell transplantation is "[a] procedure in which blood containing mobilized stem cells is collected by apheresis [a procedure in which blood is removed from a donor, a blood component, *e.g.*, white blood cells, is separated out, and the remaining blood is reinfused back into the donor], stored, and infused following high-dose chemotherapy or radiation therapy." Multiple Myeloma Research Foundation, *Myeloma Dictionary*, *at* http://www.multiplemyeloma.org/aboutmyeloma/defs.html (last visited September 16, 2002).

Dr. Samuel wrote Dr. Spears "appealing to [him] to reconsider [his] decision." Letter from Edward T. Samuel to Brent W. Spears dated March 4, 1998, at 1-2. Dr. Samuel argued that

> The treatment of multiple myeloma by high-dose chemotherapy/autologous stem cell transplantation is a well-established method of treatment with a superior response rate, complete response rate, post therapy disease-free interval, and possibly even a long-term cure in some patients, as compared to standard therapies. These facts are true for single transplant methodologies, and the statistical response rate and CR rates are improved even further with double transplants.

Id. He further argued, based on medical literature listed in his letter, that "treatment NOW with high-dose chemotherapy and autologous stem transplant . . . offers [Mr. Cicio] better chances of survival than any other available method of treatment." *Id.* at 2 (emphasis in original). While this letter made the one reference to "single transplant methodologies" quoted above, it made clear that Dr. Samuel viewed that procedure as a less appropriate treatment for Mr. Cicio than a double stem cell transplant and was not requesting approval for it. *Id.* at 1.

Three weeks later, in a letter dated March 25, 1998, Dr. Spears tersely replied that "[b]ased on the clinical peer review of the additional material, [presumably the studies referenced by Dr. Samuel in his March 4 letter,] a single stem cell transplant has been approved" but "the original request for [a] tandem stem cell transplant remains denied." Letter from Brent W. Spears to Edward T. Samuel dated March 25, 1998, at 1. Mr. Cicio, who, according to the complaint, was by March 25 no longer a candidate for a stem cell transplant, died less than two months later, on May 11, 1998. Compl. ¶ 31.

The Complaint

Bonnie Cicio filed a complaint, on behalf of herself and the estate of her late husband, in New York Supreme Court, Suffolk County, naming Vytra, Dr. Spears, and eight unknown physicians employed by Vytra ("John Does 1-8") as defendants. The complaint contains eighteen counts alleging "medical malpractice, negligence, gross negligence, intentional infliction of emotional distress, negligent infliction of emotional distress, misrepresentation, breach of contract, bad faith breach of insurance contract and violation of New York State law" based on Dr. Spears's denial of treatment to Mr. Cicio.

On May 30, 2000, the defendants removed the proceedings from New York state court to the United States District Court for the Eastern District of New York pursuant to 28 U.S.C. § 1441. On June 21, 2000, they filed a Rule 12(b)(6) motion to dismiss the complaint for failure to state a claim.

The Magistrate Judge's Report and Recommendation and the District Court's Decision

The case was referred by the district court to Magistrate Judge E. Thomas Boyle, who (1) found that removal jurisdiction obtained, and (2) recommended that the defendants' Rule 12(b)(6) motion be granted. *Cicio*, 208 F. Supp. 2d at 294-302. Magistrate Judge Boyle reasoned that the plaintiff's state law claims were preempted under §§ 502(a) and 514(a) of ERISA, 29 U.S.C. §§ 1132(a)(1)(B) & 1144(a), because the plaintiff sought "to enforce the terms of [an employee welfare benefit] plan" and that her claims were "within the scope of" § 502(a). *Cicio*, 208 F. Supp. 2d at 296-301. He concluded that both removal and dismissal were therefore required. *Id.* at 302. He also recommended that the plaintiff's state law deceptive business practices claim be dismissed because it was "exceedingly vague." *Id.* at 301-02.

In so concluding, the magistrate judge rejected several counter-arguments proffered by Ms. Cicio. First, he rejected her argument that Vytra's Agreement for Comprehensive Health Services was not a "plan" governed by ERISA. *Id.* at 297. Then he declined to endorse the plaintiff's argument that her medical malpractice claims were not preempted because they concerned "mixed eligibility and treatment decisions," as described in *Pegram v. Herdrich*, 530 U.S. 211, 229 (2000). *Cicio*, 208 F. Supp. 2d at 300-01. While many decisions by health insurance providers "involve[ ] some medical judgment," Magistrate Judge Boyle said, "[t]here is no evidence that Congress intended that these quasi-medical/administrative decisions made by a plan administrator survive ERISA preemption." *Id.* Even if such malpractice claims were not preempted, Magistrate Judge Boyle continued, Ms. Cicio had not challenged "the quality of the care but rather . . . the benefits decision that was made," and hence had alleged the kind of claim that ERISA preempted. *Id.* at 301.

The plaintiff formally objected to the magistrate judge's report and recommendation. The district court nonetheless adopted it in full. *Id.* at 291. The court agreed that Vytra's health plan was a "benefit plan" as defined by ERISA. *Id.* at 292. The court also disagreed with the renewed contention that under *Pegram*, claims for improper medical care are not preempted by ERISA. It concluded instead that because all of the plaintiff's malpractice claims "involve[d] eligibility for coverage," such that the "[d]efendants' roles, including that of Dr. Spears, were administrative," these claims concerned benefits decisions and thus were also preempted. *Id.* at 293.

The plaintiff appeals.

DISCUSSION

I. Standard of Review

We review a district court's denial of a motion to remand *de novo*. *Whitaker v. Am. Telecasting, Inc.*, 261 F.3d 196, 201 (2d Cir. 2001). We also review the district court's decision to grant a Rule 12(b)(6) motion *de novo*. *Kalnit v. Eichler*, 264 F.3d 131, 137-38 (2d Cir. 2001). Dismissal is not warranted unless "no relief could be granted under any set of facts that could be proved consistent with the allegations." *Hishon v. King & Spalding*, 467 U.S. 69, 73 (1984). We thus "tak[e] all factual allegations in the [verified] complaint as true and construe all reasonable inferences in favor of plaintiffs." *Conboy v. AT & T Corp.*, 241 F.3d 242, 246 (2d Cir. 2001) (citing *Conley v. Gibson*, 355 U.S. 41, 45-46 (1957)).

II. The Nature of the Plaintiff's Claims

Because the plaintiff asserts a variety of claims, we must first determine which of them remain on appeal. We note initially that the plaintiff's deceptive business practices claim and contract claims are no longer before us. The magistrate judge rejected the former, *see* Compl. ¶¶ 127-29, as excessively vague, *Cicio*, 208 F. Supp. 2d at 301-02, a conclusion Ms. Cicio does not challenge on appeal. And in her brief to us, Ms. Cicio renounces her breach of contract claim and bad faith breach of insurance contract claim. Plaintiff-Appellant's Br. at 1. Finally, although Ms. Cicio asserts causes of action for what she calls tortious interference with the physician-patient relationship, Compl. ¶¶ 69-76, breach of fiduciary duty, *id.* ¶¶ 77-81, negligent supervision of employees, *id.* ¶¶ 103-06, and negligent and intentional infliction of emotional distress, *id.* ¶¶ 107-17, the facts underlying these theories of recovery are entirely subsumed within her other negligence claims. We therefore treat these causes of action as alternative pleadings of her remaining medical malpractice and negligence claims.

The claims thus remaining on appeal pertain in substance to (1) the timeliness of Dr. Spears's decisions relating to Mr. Cicio's treatment, *see* Compl. ¶¶ 58-81; (2) the allegedly misleading nature of Vytra's representations about the Plan, *see* Compl. ¶¶ 82-102; and, (3) the quality of the medical decision, if any, made by the defendants with respect to Mr. Cicio's treatment, *see* Compl. ¶¶ 33-57, 103-17.[5] Both the magistrate judge, *Cicio*, 208 F. Supp. 2d at 301, and the district court, *id.*, determined that the complaint did not challenge the quality of the medical decision because "all of the Plaintiff's state law claims center on Vytra's refusal to approve coverage and thus stem from an adverse benefits determination," *id.* We disagree.

A Rule 12(b)(6) dismissal "is inappropriate unless it appears beyond doubt, even when the complaint is liberally construed, that the plaintiff can prove no set of facts which would entitle [her] to relief." *Sec. Investor Prot. Corp. v. BDO Seidman, LLP*, 222 F.3d 63, 68 (2d Cir. 2000) (internal citation and quotation marks omitted). Under this broad standard, Ms. Cicio's complaint identifies a medical decision that may be the predicate for a state-law medical malpractice claim.

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[5] We disagree with the defendants' suggestion that the plaintiff failed to perfect an appeal of the magistrate judge's report and recommendation. "A party must serve and file any objections to a magistrate judge's proposed findings and recommendations within ten days after being served with the report . . . . [F]ailure to object timely to a report waives any further judicial review of the report." *Frank v. Johnson*, 968 F.2d 298, 300 (2d Cir.) (citing 28 U.S.C. § 636(b)(1)), *cert. denied*, 506 U.S. 1038 (1992). Ms. Cicio filed her objection, that the magistrate judge's report and recommendation was "clearly erroneous," within ten days after the report was filed, hence meeting her obligation under 28 U.S.C. § 636(b)(1) and Fed. R. Civ. P. 72(a). Our cases have mandated no further specification of the basis for objection, and we decline to require additional detail in a timely objection to a magistrate judge's report and recommendation.

The complaint alleges that Dr. Spears and other physicians employed by Vytra "failed to exercise the degree of care required of them and were negligent in the provision and delivery of medically necessary care." Compl. ¶ 56. It is possible that in attacking Dr. Spears's determination that a "tandem double stem cell transplant" was an "experimental/investigational procedure[ ]," Ms. Cicio is questioning only Dr. Spears's assessment of the then-current state of medical science without regard to Mr. Cicio's particular medical affliction. This kind of decision about the scope of generally available benefits lacks a significant application of medical judgment to Mr. Cicio's case and, as the district court correctly noted, would be treated as a decision simply about the scope of benefits. But correspondence between Drs. Samuel and Spears attached to the complaint, *see* Compl. ¶¶ 15, 19, 26 & 29, and incorporated therein by reference,[6] described above, strongly suggests that Ms. Cicio is contending additionally or in the alternative that Dr. Spears, in making negligent medical decisions about Mr. Cicio's condition, was engaged in medical malpractice. The liberal construction we are required to give the complaint requires us to consider this understanding of the allegations it contains.

In his request for approval for treatment dated January 28, 1998, Dr. Samuel provided Vytra's Medical Director, Dr. Spears, with a thorough description of the case history of Mr. Cicio's illness. Letter from Edward T. Samuel to Vytra dated January 28, 1998, at 1-3. This information at least permitted Dr. Spears to make a medical determination regarding Mr. Cicio's treatment on the basis of his aggregate symptoms. And while Dr. Spears stated in reply only that

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[6] *See* Fed. R. Civ. P. 10(c) ("Statements in a pleading may be adopted by reference in a different part of the same pleading or in another pleading or in any motion. A copy of any written instrument which is an exhibit to a pleading is a part thereof for all purposes.").

the requested "procedure is not a covered benefit according to this member's plan," Letter from Brent W. Spears to Edward T. Samuel dated February 23, 1998, at 1, his decision could have rested *either* on an analysis of the appropriate treatment for Mr. Cicio's specific condition, *or* on whether in the abstract a double stem cell transplant to treat multiple myeloma was experimental given the current state of the medical art. Therefore, there is at least a possibility that the February 23rd letter reflected a medical decision.

The impression that the February 23rd letter may have embodied a medical decision is strengthened by the subsequent correspondence. Dr. Samuel's response stressed the appropriateness of double stem cell transplants in light of Mr. Cicio's particular symptoms. Dr. Spears's answer, that "[b]ased on the clinical peer review of the additional information, a single stem cell transplant has been approved [but] the original request for tandem stem cell transplant remains denied," Letter from Brent W. Spears to Edward T. Samuel dated March 25, 1998, at 1, appears to reflect a decision about an appropriate level of care. By denying one treatment and authorizing another that Dr. Samuel had not specifically requested, Dr. Spears at least seems to have been engaged in a patient-specific prescription of an appropriate treatment, and, ultimately, a medical decision that a single stem cell transplant was the appropriate treatment for Mr. Cicio.

At this stage of the litigation, reading the plaintiff's complaint and the attachments thereto together, then, we conclude that the plaintiff has alleged that the defendants made a decision that could implicate a state law duty concerning the quality of medical decision-making, in addition to and independent of her claims concerning the administration of benefits with respect to her late husband's course of care.

We do not, however, draw any conclusion about the availability of a malpractice claim in these circumstances under New York law, or whether any of the elements of such a claim, if it exists, would be satisfied by the facts as alleged in this case. We conclude only that, for the purposes of this Rule 12(b)(6) motion, the plaintiff has alleged more than an adverse benefits decision. She has also alleged that the defendants made a negligent medical determination with respect to the treatment of her late husband.

III. Subject Matter Jurisdiction

The district court concluded that defendants' removal of the complaint to federal court was proper. We agree.

A. Removal Jurisdiction

Pursuant to 28 U.S.C. § 1441(b), under which this case was removed from state to federal court, "[a]ny civil action of which the [federal] district courts have original jurisdiction [under 28 U.S.C. § 1331] . . . shall be removable . . . ." Section 1331 in turn provides that "[t]he district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States." 28 U.S.C. § 1331.

Thus, "a defendant may not remove a case to federal court [pursuant to § 1441(b)] unless the plaintiff's complaint establishes that the case 'arises under' federal law." *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 10 (1983) (emphasis omitted); *accord Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987) ("It is long settled law that a cause of action arises under federal law only when the plaintiff's well-pleaded complaint raises issues of federal law."). But all eighteen causes of action in Ms. Cicio's complaint sound in New York, not federal, law. And while the defendants' principal defense here rests on federal preemption grounds, if "the only question for decision [was] raised by a federal preemption defense" against a state law

claim, no "arising under" subject matter jurisdiction would exist. *Franchise Tax Bd.*, 463 U.S. at 12. Removal to federal district court would, in such circumstances, be improper.

Ms. Cicio's complaint may nonetheless establish § 1331 subject matter jurisdiction pursuant to federal courts' ability to "recharacterize a state law complaint" as "arising under" federal law, *Taylor*, 481 U.S. at 64, under the "complete preemption" doctrine of jurisdiction. "[W]hen Congress mandates 'complete preemption' in a specific area of the law, any civil complaint raising a state law claim in that area is of necessity so federal in character that it arises under federal law . . . and permits removal to federal court under 28 U.S.C. § 1441." *Plumbing Indus. Bd. v. E.W. Howell Co.*, 126 F.3d 61, 66 (2d Cir. 1997). Complete preemption prevents plaintiffs from "deny[ing] a defendant access to federal court if the actual nature of the complaint is federal, by artfully pleading a complaint" as including solely state law claims. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1488 (7th Cir. 1996) (internal citation and punctuation omitted). We turn first to consider the complete preemption doctrine and then apply it to the circumstances of the case at bar.

B. Complete Preemption and ERISA

Complete preemption with respect to ERISA, and consequently "arising under" subject matter jurisdiction after removal from state court, has two prerequisites. "[A] state-law cause of action arises under federal law within the meaning of 28 U.S.C. § 1331, and is removable under 28 U.S.C. § 1441, if (1) the cause of action is based on a state law that is preempted by ERISA [so-called 'conflict' or 'substantive' preemption], and (2) the cause of action is 'within the scope of the civil enforcement provisions' of ERISA § 502(a), 29 U.S.C. § 1132(a)." *Romney v. Lin*, 94 F.3d 74, 78 (2d Cir. 1996) ("*Romney I*") (internal citation omitted), *reh'g denied*, 105 F.3d 806 (2d Cir.) ("*Romney II*"), *cert. denied.*, 522 U.S. 906 (1997); *accord Marcella v.*

Capital Dist. Physicians' Health Plan, Inc., 293 F.3d 42, 46 (2d Cir. 2002).

1. "Conflict" Preemption. To satisfy the first part of the test for complete preemption, state law claims must be subject to "conflict" (or "substantive") preemption by ERISA.[7] Section 514(a) of ERISA provides that ERISA "supersede[s] any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan described in section 1003(a) of this title," with exceptions not relevant here. 29 U.S.C. § 1144(a) (emphasis added); *cf. id.* § 1002(1) (defining "employee welfare benefit plan" to include "any plan, fund, or program . . . established or maintained by an employer or by an employee organization . . . for the purpose of providing for its participants or their beneficiaries . . . medical, surgical, or hospital care or benefits"). "[A] state law relates to an ERISA plan 'if it has a connection with or reference to such a plan.'" *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)).

Glossing the "reference to" language of *Shaw*, the Supreme Court has explained that "[w]here a State's law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation . . . that 'reference' will result in pre-emption." *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr. N.A.*, 519 U.S. 316, 325 (1997) (internal citations omitted). We find no such reference here. Because the state laws invoked by Ms. Cicio, such as that respecting medical malpractice doctrine, act neither immediately nor exclusively

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[7] "Conflict" preemption arises when federal law's constitutionally mandated supremacy over state law requires that federal law displace conflicting state law as a rule of decision. *See Darcangelo v. Verizon Communications, Inc.*, 292 F.3d 181, 186-87 (4th Cir. 2002).

on ERISA plans and because such plans are not "essential to" the laws' operation, we need consider this question no further.

But a state law is also conflict preempted if it has a "connection with" an ERISA plan. *Egelhoff*, 532 U.S. at 147. The requisite connection exists if a law "mandates employee benefit structures or their administration or provides alternative enforcement mechanisms [to ERISA]." *Plumbing Indus. Bd.*, 126 F.3d at 67 (quoting *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995); internal punctuation omitted); *accord HMI Mech. Sys., Inc. v. McGowan*, 266 F.3d 142, 149 (2d Cir. 2001). In this analysis, a court "look[s] both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive as well as to the nature of the effect of the state law on ERISA plans." *Dillingham Constr.*, 519 U.S. at 325 (internal citations and punctuation omitted). Complete preemption in the case at hand, if it exists, must therefore rest on the "connection with" theory.

2. "Within the scope of" the civil enforcement provisions of ERISA. Conflict preemption "alone is insufficient to support removal jurisdiction." *Romney I*, 94 F.3d at 78. As noted above, a state law action preempted by ERISA establishes "arising under" jurisdiction only if, under the second part of the complete preemption test, it is *also* a "cause[ ] of action within the scope of the civil enforcement provisions of [ERISA] § 502(a)." *Taylor*, 481 U.S. at 66 (emphasis added); *accord Plumbing Indus. Bd.*, 126 F.3d at 69; *Romney II*, 105 F.3d at 812-13.

Section 502(a)(1)(B) of ERISA provides for actions "to recover benefits due . . . under the terms of [a] plan, to enforce . . . rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Congress thereby created "a comprehensive civil enforcement scheme that represents a

careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). "In enacting §§ 502(a) and 514(a), Congress sought to eliminate alternative state law remedies for benefit plan participants and beneficiaries, relegating such persons to . . . six well-integrated remedies . . . ." *Plumbing Indus. Bd.*, 126 F.3d at 68; *see also Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985) (describing ERISA's "interlocking, interrelated, and interdependent remedial scheme").

The second component of the complete preemption test is met if state law causes of action that are pleaded seek to vindicate rights already protected by § 502(a). These claims are then recharacterized as federal in nature and serve as a basis for "arising under" subject matter jurisdiction. A cause of action is therefore "within the scope of" § 502(a) "only if . . . [it] is properly characterized as seeking 'to recover benefits due to [the plaintiff] under the terms of [the] plan, to enforce his [or her] rights under the terms of the plan, or to clarify his [or her] rights to future benefits under the terms of the plan.'" *Lupo v. Human Affairs Int'l, Inc.*, 28 F.3d 269, 272 (2d Cir. 1994) (quoting 29 U.S.C. § 1132(a)(1)(B)). But "[a] suit need not be a cognizable, winning claim under § 502(a) in order to fall 'within the scope' of the provision for purposes of the jurisdiction analysis." *Plumbing Indus. Bd.*, 126 F.3d at 69. Any "state cause of action that acts as an alternative means of vindicating the rights protected by § 502(a) is 'within the scope' of the section even if the suit is directed against a defendant not liable under ERISA." *Id.* Jurisdiction exists, then, even over *unsuccessful* attempts to circumvent § 502(a).

With these two prerequisites of complete preemption in mind, we turn to consider whether there is complete preemption of the plaintiff's timeliness and misrepresentation claims so as to permit their removal.

C. Removal Jurisdiction over the Timeliness and Misrepresentation Claims

1. The Timeliness Claims. The plaintiff's timeliness claims rest on "the defendants' [alleged] failure to conduct an appeal of their denial of care . . . in a timely fashion . . . ." Compl. ¶ 66. The plaintiff specifically alleges negligence in defendants' failure to respond promptly to Dr. Samuel's January 28, 1998 request. Her claim draws on New York law to the effect that "a determination involving continued or extended health care services, or additional services for an enrollee undergoing a course of continued treatment," must be made and communicated "by telephone and in writing within one business day of receipt of the necessary information." N.Y. Pub. Health Law § 4903(3); *see also* Compl. ¶ 24; Plaintiff-Appellant's Br. at 2. We conclude that such claims are conflict preempted by § 514. We also conclude that the timeliness claims are "within the scope of" § 502(a). Removal jurisdiction therefore properly obtains over them.

First, with regard to conflict preemption, ERISA already mandates that employee benefit plans "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied." 29 U.S.C. § 1133(1). Regulations issued by the Secretary of Labor pursuant to 29 U.S.C. § 1135 "set[ ] forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries." 29 C.F.R. § 2560.503-1(a). A request "to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible . . . and the plan administrator shall notify the claimant . . . within 24 hours after receipt of the claim by the plan . . . ," *id.* § 2560.503-1(f)(2)(ii)(B). Otherwise, a plan administrator must generally act within ninety days, *id.* § 2560.503-1(f)(1).

The New York law that plaintiff attempts to enforce thus has an "effect on the primary administrative functions of benefit plans," *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989), and conflicts with regulations established pursuant to ERISA. By requiring that health benefits plans reply to requests for "additional services for . . . continued treatment" within twenty-four hours, N.Y. Pub. Health Law § 4903(3), New York law establishes a different rule from ERISA's, which requires action within the same time-frame only if a claim involves continuing "urgent care," 29 C.F.R. § 2560.503-1(f)(2)(ii)(B).[8]

The second part of the test for complete preemption—that the cause of action be "within the scope of" § 502(a)—is also satisfied because the plaintiff's timeliness claims are "an alternative mechanism . . . for enforcing the rights protected by ERISA." *Plumbing Indus. Bd.*, 126 F.3d at 68. Under § 502(a)(1), a participant or beneficiary of a plan may file suit "to enforce his [or her] rights under the terms of the plan." 29 U.S.C. § 1132(a)(1)(A). And an enrollee in an

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[8] In reaching this conclusion, we tread a well-worn path. "[C]ommon law causes of action . . . based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet the criteria for pre-emption under § 514(a)." *Pilot Life*, 481 U.S. at 48. In light of *Pilot Life*'s conclusion, circuit courts have uniformly concluded that tort claims of negligence based solely on delay in processing are preempted. *See, e.g.*, *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 273 (3d Cir. 2001) (preempting "a claim that the HMO or plan administrator delayed"); *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1007-08 (9th Cir. 1998) (rejecting a state law wrongful death suit based on improper processing of a claim), *cert. denied*, 528 U.S. 870 (1999); *Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270, 1273-74 (10th Cir.) (preempting a claim of negligence in approving treatment), *cert. denied*, 519 U.S. 816 (1996); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131-32 (9th Cir. 1993) (preempting a wrongful death action based on failure to approve treatment in a timely fashion), *cert. denied*, 511 U.S. 1052 (1994).

ERISA-governed plan has a right to timely determinations. *See* 29 C.F.R. § 2560.503-1(f)(2)(ii)(B). The Cicios could thus have brought suit for injunctive relief under § 502(a)(1)(B) in February or March 1998 to seek to obtain authorization for the double stem cell transplant. An attempt to vindicate the same interest through a state law mechanism is an action "within the scope of" § 502(a), *Taylor*, 481 U.S. at 66.

The timeliness claims therefore meet the second prerequisite to complete preemption. Removal jurisdiction with respect to them is thus established.

2. The Misrepresentation Claims. The plaintiff also alleges that Vytra "intentionally withheld information from its customers regarding defendants' intention to interpret its policies in a manner inconsistent with, and contrary to, its own understanding of the policies' provisions" before the Cicios accepted coverage, and upon execution of the Plan, "adopted inconsistent and incorrect interpretations of the term 'medical necessity' and other terms contained in the Policy." Compl. ¶¶ 83, 90. These claims, too, are subject to complete preemption.

First, "ERISA preempts state common law claims of fraudulent or negligent misrepresentation when the false representations concern the existence or extent of benefits under an employee benefit plan." *Griggs v. E.I. Dupont de Nemours & Co.*, 237 F.3d 371, 378 (4th Cir. 2001). In other words, the cause of action that the plaintiff's misrepresentation claims rely upon is conflict preempted.

Second, the misrepresentation claims rest on the allegation that Vytra had an obligation under the terms of the plan to provide benefits that it failed to provide. The claims thus seek to vindicate rights accruing under the plan. But ERISA § 502(a)(1)(B) allows recovery of "benefits due . . . under the terms of [a] plan." 29 U.S.C. § 1132(a)(1)(B). And we have previously rejected similar state law claims—to the

effect that a plan administrator misrepresented the availability of benefits under a plan—as "attempt[s] to supplement the plan's express provisions and secure an additional benefit." *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 10 (2d Cir. 1992); *see also Carlo v. Reed Rolled Thread Die Co.*, 49 F.3d 790, 793-94 (1st Cir. 1995) (concluding that a negligent misrepresentation claim was preempted because it sought allegedly promised plan benefits as damages).[9] As an alternative means of enforcing plan-related rights created by ERISA, the misrepresentation claims are then also "within the scope of § 502(a)," *Taylor*, 481 U.S. at 66.

Both prerequisites for complete preemption are satisfied, so removal jurisdiction was properly exercised by the district court over the misrepresentation claims too.

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[9] The complaint might be read to reference representations made before the Cicios entered the contract, and some courts have concluded that a misrepresentation claim based on actions before a contract has been signed are not preempted. *See, e.g., Neuma, Inc. v. AMP, Inc.*, 259 F.3d 864, 880-81 (7th Cir. 2001). But the misrepresentations in *Neuma* concerned the value of the benefits package as a whole, not whether the package contained specific benefits. *See id.* at 869. The misrepresentation claim in *Neuma*, unlike those made by Ms. Cicio, did not require an interpretation of the terms of the plan.

In other cases concerning alleged misrepresentations made before a plan contract commenced, courts have found state law claims preempted because the claims seek, in essence, to vindicate contractual rights. *See Hall v. Blue Cross/Blue Shield of Ala.*, 134 F.3d 1063, 1065 (11th Cir.) (preempting a state law claim based on alleged fraudulent marketing because "no court will be able to determine whether [the plaintiff] has been fraudulently induced without resorting to the written policy") (emphasis in original omitted), *reh'g en banc denied*, 158 F.3d 590 (11th Cir. 1998); *Degnan v. Publicker Indus., Inc.*, 83 F.3d 27, 30 (1st Cir. 1996) (rejecting as preempted a claim of misrepresentation). The misrepresentation claims in the case at bar are more akin to the latter than those alleged in *Neuma* insofar as they seek to recover benefits allegedly due under the plan.

D. Supplemental Jurisdiction

Under 28 U.S.C. § 1367(a), a district court has "supplemental jurisdiction over all other claims that are so related to claims in the action within such original jurisdiction that they form part of the same case or controversy" once original jurisdiction is established. *Id.* A state law claim forms part of the same controversy if it and the federal claim "derive from a common nucleus of operative fact." *City of Chicago v. Int'l Coll. of Surgeons*, 522 U.S. 156, 165 (1997) (quoting *United Mine Workers of Am. v. Gibbs*, 383 U.S. 715, 725 (1966)); *see also Gibbs*, 383 U.S. at 725 ("[I]f, considered without regard to their federal or state character, a plaintiff's claims are such that he would ordinarily be expected to try them all in one judicial proceeding, then, assuming substantiality of the federal issues, there is *power* in federal courts to hear the whole.") (emphasis in original).

All Ms. Cicio's claims "derive from a common nucleus of operative fact," *Gibbs*, 383 U.S. at 725, to wit, the denial by Dr. Spears of authorization for a double stem cell transplant. All relevant events allegedly transpired between January 28, 1998, when Dr. Samuel first requested the double stem cell transplant, and May 11, 1998, when Mr. Cicio died. The plaintiff "would ordinarily be expected to try [ ] all [of her claims] in one judicial proceeding." *Id.* Subject matter jurisdiction thus exists over Ms. Cicio's malpractice claims under 28 U.S.C. § 1367(a), irrespective of whether, standing alone, they are removable.

IV. Dismissal of the Timeliness and Misrepresentation Claims

After determining that the entire complaint was properly removable so that subject matter jurisdiction obtained, the magistrate judge and district court determined that the defendants' Rule 12(b)(6) motion should be granted because the plaintiff's asserted causes of action were all preempted

by ERISA. *Cicio*, 208 F. Supp. 2d at 293, 302. The preceding jurisdictional analysis, in addition to establishing that removal was appropriate, demonstrates that dismissal of the timeliness and misrepresentation claims was appropriate.

As discussed above, the timeliness and misrepresentation claims brought under New York state law are both "alternative mechanism[s] . . . for enforcing the rights protected by ERISA." *Plumbing Indus. Bd.*, 126 F.3d at 68. For that reason, they are conflict preempted by ERISA because they attempt to regulate in an area where Congress, through ERISA, has swept away all state regulation. In the preemptive shadow of ERISA, no state cause of action can lie, *cf. id.* at 68-70 (dismissing state law claims for similar reasons), and therefore these claims were rightly dismissed. All that remains for our consideration, then, are the medical malpractice claims.

V. Preemption of Medical Malpractice Claims

The question whether a state law medical malpractice claim brought with respect to a medical decision made in the course of prospective utilization review by a managed care organization or health insurer is preempted under ERISA § 514, and therefore beyond the reach of state tort law, is one of first impression in this Circuit. We conclude, largely on the basis of recent Supreme Court decisions, that such a state law claim is not preempted.

A. The Practice of Utilization Review

The plaintiff's medical malpractice claims are based on Dr. Spears's denial of coverage for a double stem cell transplant for Mr. Cicio. Letter from Brent W. Spears to Edward T. Samuel dated February 23, 1998, at 1. Dr. Spears's decision occurred in the course of Dr. Samuel's attempt to obtain authorization for the double stem cell transplant from Vytra. Compl. ¶¶ 15, 19-21. The complaint then details a process of utilization review, and it is the

nature of this procedure, and its relation to ERISA, upon which we now focus.

Utilization review usually involves "prospective review by a third party of the necessity of medical care." *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1326 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992); *see also Pegram*, 530 U.S. at 219.[10] "[T]he typical prospective review system requires some form of pre-admission certification by a third party," *Corcoran*, 965 F.2d at 1327, such as Vytra's Medical Director, Dr. Spears. "Although prospective utilization review involves no traditional face-to-face clinical encounter, it is still quasi-medical in nature. It necessarily involves evaluation of data collected in such an encounter." *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1, 5 n.5 (1st Cir. 1999); *see also Corcoran*, 965 F.2d at 1331 (characterizing utilization review as a medical decision); Note, Jonathan J. Frankel, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1318 (1994) ("Cost-containment programs . . . redistribute what we normally consider 'medical authority' to nontraditional actors."). Prospective utilization review blurs boundaries between the traditionally "distinct sphere of professional dominance and autonomy" of the medical profession on the one hand, Paul Starr, *The Social Transformation of American Medicine* 27 (1982), and the managerial domain on the other. As such, it represents a development apparently unforeseen

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[10] The term "utilization review" is also applied in some federal statutes. For example, the determination by a hospital or skilled nursing care facility that an admission or continued stay is or is not medically necessary in connection with the availability of Medicare coverage is made by a "utilization review committee" established under the dictates of the Social Security law. *See Kraemer v. Heckler*, 737 F.2d 214, 214-16 (2d Cir. 1984) (describing Medicare procedures under 42 U.S.C. § 1395x and 42 C.F.R. § 405.1035).

at the time of ERISA's enactment. *See* Jeffrey E. Shuren, *Legal Accountability for Utilization Review in ERISA Health Plans*, 77 N.C. L. REV. 731, 733 (1999).

Moreover, as other courts have noted, "a system of prospective decisionmaking influences the beneficiary's choice among treatment options to a far greater degree than does the theoretical risk of disallowance of a claim facing a beneficiary in a retrospective system." *Corcoran*, 965 F.2d at 1332; *accord Danca*, 185 F.3d at 5 n.5. And, "[i]n many instances, a denial of coverage results in the patient forgoing the procedure altogether." J. Scott Andresen, *Is Utilization Review the Practice of Medicine?*, 19 J. LEGAL MED. 431, 432 (1998). Thus, decisions with a medical component—i.e., involving the exercise of medical judgment in relation to a particular patient's symptoms—are made in the course of utilization review by staff who are independent of and separate from the locus of traditional medical decision-making authority. These medical decisions have possibly dispositive consequences for the course of treatment that a patient ultimately follows.

B. ERISA's Preemptive Scope

The Supreme Court, in its early pronouncements on ERISA preemption, suggested that the sweeping reference to "any and all State laws [that] . . . relate" to benefits plans in ERISA's preemption provision, 29 U.S.C. § 1144(a), entailed an expansive preemptive effect that corresponded to the provision's broad wording. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990); *Pilot Life*, 481 U.S. at 47, *Russell*, 473 U.S. at 146-47; *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). Since then, however, the Court has "temper[ed] the assumption that the ordinary meaning [of § 514] . . . accurately expresses the legislative purpose . . . with the qualification that the historic police powers of the States were not meant to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S.

355 (2002) (internal citations and punctuation omitted). In recent discussions of ERISA preemption, it has even been hinted that "the criteria set forth in [early cases like *Shaw* and its progeny] have in effect been abandoned." *Dillingham Constr.*, 519 U.S. at 335 (Scalia, J., concurring).

Specifically, the Supreme Court has rejected the notion that any finely filigreed connection between ERISA and a state law establish ERISA preemption, and, instead, has held that a court must begin with the presumption that "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestations of congressional purpose." *Pegram*, 530 U.S. at 237; *accord Rush Prudential*, 122 S. Ct. at 2171; *see also De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813-14 (1997) (applying a presumption that "Congress does not intend to supplant state law"; internal citation omitted); *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654 (1995) (same). Moving beyond presumptions, the Supreme Court has also, in its own words, thrown "cold water" on the idea that state regulation of health and safety is necessarily preempted even when it overlaps with rights protected by ERISA. *Pegram*, 530 U.S. at 237 (citing *Travelers*, 514 U.S. at 654-55).

In deciding the preemption question, it is also noteworthy that ERISA's "repeatedly emphasized purpose [is] to protect *contractually* defined benefits." *Russell*, 473 U.S. at 148 (emphasis added); *accord Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (reiterating the focus on "contractually defined benefits") (internal citation omitted); *Russell*, 473 U.S. at 147 (noting the centrality of "contractually authorized benefits"). Indeed, one of ERISA's stated goals involves increasing "the likelihood that full benefits will be paid to participants and beneficiaries of [covered] plans." 29 U.S.C. § 1001b(b)(1). State medical malpractice law, by contrast, even if implicated by the execution of a benefits decision, involves the application of

duties of conduct that are defined independent of ERISA plans.[11] As such, it is not among the "rights and expectations brought into being by [ERISA]," *Ingersoll-Rand*, 498 U.S. at 137 (internal citation omitted), that § 502(a) is designed to protect.

We must therefore ask whether the plaintiff's medical malpractice causes of action "relate to" the benefits plan administered by Vytra, keeping in mind both the Supreme Court's warning that state law regulation of medical practice is not to be lightly disturbed, and the observation that ERISA's primary focus is the protection of contractual rights defined by benefits plans.

C. The Preemption of Medical Malpractice Claims Against Utilization Review Decisions

1. Pegram v. Herdrich. At first blush, the defendants' contention that Dr. Spears's decision concerned a benefits determination about what medical treatments Mr. Cicio could receive pursuant to the plan, a decision that can only be challenged in a § 502(a)(1)(B) action, has considerable force. Other courts addressing similar facts have concluded that malpractice claims based on utilization review decisions are indeed preempted by § 514. They have reasoned, first, that utilization review involves "medical decisions as part and parcel of [a plan's] mandate to decide what benefits are available," and then held that, as benefits decisions, utilization review decisions can be challenged only in a § 502(a)(1)(B) action. *Corcoran*, 965 F.2d at 1332; *see also Jass*, 88 F.3d at 1489-90 (holding preempted a negligence action against a utilization review agent); *Tolton v. Am.*

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[11] Even if, absent a benefits contract, no medical care would in fact have been furnished, so that the medical judgment in one sense is a "benefit" and a direct consequence of the exercise of a contractual right, the state law obligation to provide care of a given level of quality when providing care is nonetheless distinct from the contract.

Biodyne, Inc., 48 F.3d 937, 942 (6th Cir. 1995) (rejecting as preempted a malpractice claim against a utilization review decision because the defendants "were determining what benefits were available . . . under the plan"); *Brandon v. Aetna Servs., Inc.*, 46 F. Supp. 2d 110, 113-14 (D.Conn. 1999) (similar); *cf. Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, 534 (5th Cir.) ("ERISA preempts malpractice suits against doctors making coverage decisions in the administration of a plan . . . ."), *reh'g in banc denied*, 220 F.3d 641 (5th Cir. 2000), *vacated and remanded on other grounds sub nom. Montemayor v. Corporate Health Ins.*, 536 U.S. 935 (2002); *Rice v. Panchal*, 65 F.3d 637, 644 (7th Cir. 1995) (holding that "where the state law has the effect of creating a qualitative standard . . . by which the performance of the contract is evaluated, then that state law is completely preempted"). These cases rest on the proposition that a decision cannot be the basis of a malpractice claim even if it involves the exercise of medical judgment if at the same time it has a benefits determination component. According to these cases, the performance of contractual interpretation in order to determine benefits triggers preemption without regard to the medical content of a decision.

But *Corcoran*, *Jass*, and *Tolton* were decided before the Supreme Court's recent retrenchment of ERISA preemption's margins, and before the Court, in its unanimous decision in *Pegram v. Herdrich*, addressed (albeit in dicta) medical malpractice actions against those engaged in medical decision making.

Pegram concerned a defendant physician who "decided (wrongly, as it turned out) that [the plaintiff's] condition did not warrant immediate action; the consequence of that medical determination was that [the defendant HMO] would not cover immediate care, whereas it would have done so if

[the defendant physician] had made the proper diagnosis and judgment to treat."[12] 530 U.S. at 229. *Pegram* addressed only whether an HMO had, by its method of sharing profits with doctors, breached its fiduciary duty to members, disclaiming any suggestion that it was addressing the interaction between § 502 and state law claims. 530 U.S. at 229 n.9. *Pegram* is nonetheless relevant to the case at hand because of the reasoning upon which the Court's conclusion was based. The Court decided that no fiduciary breach action could be brought under ERISA because, in part, such an action would be a "mere replication of state malpractice actions with HMO defendants," *id.* at 236. The creation of a fiduciary breach action through "the formulaic addition of an allegation of financial incentive [to a malpractice claim] would do nothing but bring the same claim into a federal court under federal-question jurisdiction." *Id.* at 235. We thus infer that the continued availability of some state law malpractice actions based on at least some varieties of utilization review decisions was a predicate of the Court's holding.

But the *Pegram* opinion has further ramifications for our analysis because of its detailed description and analysis of decision-making in the context of health care provision. The Court categorized the defendant Dr. Pegram's act as a "mixed eligibility and treatment" decision, i.e., an "eligibility decision [that] cannot be untangled from physicians' judgments about reasonable medical treatment." *Id.* at 229. The *Pegram* Court then explained:

What we will call pure "eligibility decisions" turn on the

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[12] A patient, the plaintiff Cynthia Herdrich, had experienced pain in her groin, and submitted to an examination by Dr. Pegram. 530 U.S. at 215. Despite discovering a significant inflamed mass in Herdrich's abdomen, Dr. Pegram did not order an immediate diagnostic ultrasound. *Id.* Before Herdrich was to have received the ultrasound, her appendix ruptured. *Id.*

> plan's coverage of a particular condition or medical procedure for its treatment. "Treatment decisions," by contrast, are choices about how to go about diagnosing and treating a patient's condition: *given a patient's constellation of symptoms, what is the appropriate medical response?*
>
> These decisions are often practically inextricable from one another .... This is so *not merely because*, under a scheme like [the benefits plan in *Pegram*], *treatment and eligibility decisions are made by the same person, the treating physician. It is so because a great many and possibly most coverage questions are not simple yes-or-no questions*, like whether appendicitis is a covered condition (when there is no dispute that a patient has appendicitis), or whether acupuncture is a covered procedure for pain relief (when the claim of pain is unchallenged). The more common coverage question is a when-and-how question. Although coverage for many conditions will be clear and various treatment options will be indisputably compensable, physicians still must decide what to do in particular cases. The issue may be, say, whether one treatment option is so superior to another under the circumstances, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement that conditions the HMO's obligation to provide *or pay for* that particular procedure at that time in that case.

Id. at 228-29 (citations omitted; emphasis added).

Pegram thus suggests that some decisions involve interpretation of a benefits contract, eligibility decisions, and some involve application of medical judgment to a particular patient's condition, treatment decisions. And these two categories overlap. The resulting third category, described in *Pegram*, of "mixed eligibility and treatment decisions," *id.* at 229, is not limited to decisions made by treating physicians, such as Dr. Pegram, who both assess which benefits a plan

provides and make treatment decisions. A decision about who will "pay for" a procedure, even when this decision is not made by a "treating physician," is also a "mixed eligibility and treatment decision" if it involves answering the question: "given a patient's constellation of symptoms, what is the [most] appropriate medical response?" *Id.* at 228-29. In other words, even if a physician does not directly control, direct, or influence a plaintiff's treatment, and even if the sole consequence of a physician's decision is reimbursement or its denial, that decision may nonetheless be a mixed eligibility and treatment decision like Dr. Pegram's. *Id.*

Pegram thus alters the framework used in *Corcoran*, *Jass*, and *Tolton*, in which a decision must be about either "treatment" or "eligibility," and in which any element of benefits determination suffices to make a decision an "eligibility" decision that may only be challenged in a § 502(a) action. The *Pegram* court's analysis suggests instead that courts should recognize that "[i]n recent years, the medical profession's monopoly on the authority to define appropriate health care outcomes for society has been severely eroded." Frankel, *supra*, at 1320; *see also* Starr, *supra*, at 27 (describing threats to physician autonomy). The "separation between professional providers and lay financiers," which *Corcoran*, *Jass*, and *Tolton* presumed, "no longer exists." Frankel, *supra*, at 1320; *cf.* Starr, *supra*, at 447 (observing "increasing corporate [as opposed to professional] influence over the rules and standards of medical care"); Shuren, *supra*, at 748 (noting that utilization review agents "interpos[e] themselves into medical decisionmaking"). Decisions now regularly made by third-party payers, such as "whether one treatment option is so superior to another under the circumstances, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement" in a health benefits contract, "cannot be untangled from physicians' judgments about reasonable medical treatment," *Pegram*, 530 U.S. at

229. And such coverage decisions based on medical determinations often have an outcome-determinative effect. *See Corcoran*, 965 F.2d at 1332; *Danca*, 185 F.3d at 5 n.5; Andresen, *supra*, at 432. Among such decisions, noted the *Pegram* Court, are ones concerning "the experimental character of a proposed course of treatment." *Pegram*, 530 U.S. at 229-30.

The defendants' decision in this case, in the current procedural posture of this appeal, must be treated as a mixed decision because it allegedly involved both an exercise of medical judgment and an element of contract interpretation.

2. Applying Pegram's Tripartite Analysis to ERISA Preemption. We conclude that a state law malpractice action, if based on a "mixed eligibility and treatment decision," is not subject to ERISA preemption when that state law cause of action challenges an allegedly flawed medical judgment as applied to a particular patient's symptoms. We reach this conclusion by applying the presumptions previously discussed, our understanding of congressional intent in enacting ERISA, and the analytic framework established in *Pegram*.

At the threshold, we decline to adopt the categorical distinction between "quality of care" decisions and "benefits administration" questions applied by other courts in the ERISA preemption context, *Pryzbowski*, 245 F.3d at 279, and by the district court in the case at bar, *Cicio*, 208 F. Supp. 2d at 293. To frame the issue in that fashion is to ignore the nature of "countless medical administrative decisions every day" in which "the eligibility decision and the treatment decision [are] inextricably mixed." *Pegram*,

530 U.S. at 229. *Pegram* teaches that this dichotomy is no longer tenable.[13]

Further, *Pegram* demonstrates that the mere presence of an administrative component in a health care decision no longer has determinative significance for purposes of preemption analysis when the decision also has a medical component. In its brief discussion of the "puzzling issue of preemption," the *Pegram* Court rejected one of the plaintiff's arguments as "a prescription for preemption of state malpractice law." *Id.* at 236. The Court said, as we have noted, that previous cases had already thrown "cold water on the preemption theory [with regard to state law malpractice claims]." *Id.* at 237. The Court's analysis strongly suggests, without holding, that the plaintiff's malpractice action against Dr. Pegram would not be preempted even though Dr. Pegram simultaneously made a contractual interpretation concerning Herdrich's eligibility for given benefits, and that a defendant can no longer simply point to the overlay of medical decision-making on contractual claims and ask the court to conclude that, because ERISA preempts the contract claims, it also preempts all state tort-law claims based on the same decision.

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[13] We think that Judge Calabresi, in his partial dissent, fails sufficiently to take into account the shift in the legal and medical landscape clearly marked by the unanimous *Pegram* decision. The question is no longer an either/or between eligibility and treatment—whether, as Judge Calabresi phrases it, the plaintiff's action is "essentially [a suit] against an insurance provider for negligently failing to give the coverage contracted for, or . . . against a medical care provider for negligent failure to treat." Dissent at 108. Frequently, health care decisions (including perhaps Dr. Spear's)—so-called "mixed eligibility and treatment decisions," *Pegram*, 530 U.S. at 229—now contain elements of both. And the medical element can give rise to "state malpractice actions with HMO defendants," *id.* at 236, if state law so provides, even if the defendants were simultaneously "determining the scope and coverage of an ERISA-plan contract," dissent at 109.

As we have explained, nothing in ERISA suggests that Congress intended any displacement of "the quintessentially state-law standards of reasonable medical care" as applied to the medical component of a mixed decision. *Rush Prudential*, 122 S. Ct. at 2171. And ERISA requires that we distinguish between "contractually defined benefits," *Russell*, 473 U.S. at 148, and those rights that state law delimits independent of benefits plans, such as medical quality standards, which hinge instead on statutory and common law development of malpractice law unique to each state.

Finally, we note our skepticism of a line of reasoning that would draw from "a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans," *Shaw*, 463 U.S. at 90, the elimination of protective standards of professional conduct. We see no reason then to bar as preempted state law malpractice actions that rest on the application of standards for medical decision-making—which are established by states independent of and prior to health benefits contracts—to "a patient's constellation of symptoms," *Pegram*, 530 U.S. at 228. *Accord Isaac v. Seabury & Smith, Inc.*, 2002 WL 1461710, *6-*8, 2002 U.S. Dist. LEXIS 12413, *19-*28 (S.D.Ind. July 5, 2002) (finding no complete preemption of a medical malpractice action based upon a utilization review decision).

Focusing on mixed eligibility and treatment decisions, then, we conclude that § 514 preemption does not obtain with regard to those claims predicated on the violation of a state tort law by a failure to meet a state-law defined standard of care in diagnosing or recommending treatment of a plaintiff "patient's constellation of symptoms," *Pegram*, 530 U.S. at 228.

3. The Distinction Between Treating Physicians and Utilization Review Agents. The district court appeared to distinguish between a tort action based on a pre-certification

decision, such as Dr. Spears's decision here, and one based on a contemporaneous treatment decision, such as Dr. Pegram's. *See Cicio*, 208 F. Supp. 2d at 293 (distinguishing between Dr. Pegram's decision and an anterior decision about "eligibility for coverage"). In support of this distinction, it might be argued that, in the pre-certification context, the treatment analysis precedes the contract interpretation question such that adjudication of a tort action *necessarily* involves an interpretation of the ERISA contract, which in turn triggers preemption. And it might be further argued that in contemporaneous treatment questions, the contract interpretation question does not play the same intervening role.

But we are not convinced such a distinction can in fact be drawn. *Pegram*, as noted, did not distinguish between the decisions of a treating physician empowered to interpret a benefits contract, and medical administrative decisions executed prior to the delivery of care. Its category of mixed eligibility and treatment decisions consisted of "when-and-how question[s]," including, critically, the question whether "a decision to proceed with [a procedure] would meet the medical necessity requirement that conditions the HMO's obligation to provide *or pay for* that particular procedure." *Pegram*, 530 U.S. at 228-29 (emphasis added). Even when making decisions about whether to pay for particular procedures, "physicians still must decide what to do in particular cases" on the basis of medical assessments. *Id.* at 229.

And, "[i]n practical terms, . . . eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment," or, at least, the untangling will in many instances be no easy task. *Id.* For instance, some managed care organizations require that utilization review agents "negotiate with the treating physician to achieve conformity" in levels of care provided. Shuren, *supra*, at 746-47. That sort of negotiation is reflected in the correspondence

between Drs. Spears and Samuel. While Dr. Samuel initiated negotiations with a detailed description of Mr. Cicio's status, Dr. Spears parried with an assertion of the requested treatment's experimental nature. Dr. Samuel then supplemented his argument with support from the medical literature. In response, Dr. Spears apparently made a patient-specific prescription of appropriate treatment by denying one treatment and authorizing another that Dr. Samuel had not requested. At least on the basis of the material on which we review the grant of the Rule 12(b)(6) motion by the district court, we cannot identify distinct moments at which treatment decisions as distinct from eligibility decisions were made in the course of this negotiation, let alone the sequence of such decisions.

In the *Pegram* context of contemporaneous treatment decisions, too, how to distill the moment of the eligibility determination from the facts is far from obvious. Examining the Supreme Court's description of Dr. Pegram's behavior, we cannot determine whether she (1) thought first about how soon Herdrich needed an ultrasound and then considered whether the plan comprised ultrasound tests in a given medical facility, or (2) considered first which benefits were available, and only then analyzed which one was medically warranted within that constrained range. *See Pegram*, 530 U.S. at 215. In other words, it is difficult, at best, to determine whether her violation of the standard of medical care was apart from and independent of a determination of benefits, or whether the benefits determination preceded and controlled the medical determination.

In sum, it would likely often be difficult to delve into physicians' minds to examine their decisions, which are frequently executed in very brief time-periods and under tremendous pressures, to determine what part of them is medical and what part is administrative. Nor do we think it likely that significant contract interpretation issues will arise in an ensuing tort action. Assuming *arguendo* that Ms. Cicio

were to establish that Dr. Spears's decision violated a state law duty of professional care, we are hard pressed to see how the defendants could successfully contend—as a defense to the *tort* action—that the *contract* permitted them to violate a state law duty standard of care.[14]

D. Caveats

We underscore the fact that this case comes before us on appeal from the grant of a Rule 12(b)(6) motion to dismiss. We therefore hold only that a set of facts consistent with the allegations contained in the complaint would permit the granting of relief-oddly, in this case, remand to state court for a determination, *inter alia*, of whether the complaint states a cause of action under the law of New York. If Dr. Spears's actions that are the subject of the complaint indeed constituted a medical decision or a mixed medical and eligibility decision, then Ms. Cicio's remaining medical malpractice claims should not be dismissed, but remanded to state court for resolution. *See Giordano v. City of N.Y.*, 274 F.3d 740, 754-55 (2d Cir. 2001). It may nonetheless be that, as a matter of fact, Dr. Spears's decision was purely one concerning eligibility, *i.e.*, a determination that, without regard to Mr. Cicio's "constellation of symptoms" but in the abstract, double cell stem transplants were experimental as treatment for multiple myeloma. In that case, the claims would be completely preempted by ERISA and therefore subject to dismissal. We therefore do not rule out the possibility that the defendants can demonstrate, *as a matter*

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[14] Certainly, it would be a different matter if the complaint alleged only that the health benefits plan did not cover a given procedure without regard to what symptoms a patient presented. In that case, the defendants would in fact be contending that they made no medical decision that could be subject to state law standards for medical care, but rather only interpreted the contract. In such cases, a court would have to make a threshold determination, as we have done in the case at bar, as to whether a medical decision made by the defendants has been alleged.

of fact, that dismissal of the complaint is warranted. We leave it to the district court to determine what proceedings, if any, would be appropriate to that end.

Finally, we reiterate that we do not decide under what circumstances, if any, the decisions made by Vytra or Dr. Spears, or utilization review decisions generally, may when negligently made be actionable under New York law. Perhaps they never are. Unless the district court determines that Dr. Spears was in fact making pure eligibility decisions with respect to Mr. Cicio's health care and dismisses the claim on that ground, that will be a question for the New York courts to decide upon remand.

CONCLUSION

We affirm the district court's disposition of the timeliness and misrepresentation claims, but vacate its resolution of the medical malpractice claims and remand for further proceedings consistent with this opinion.

CALABRESI, Circuit Judge, dissenting in part.

How can one object to the result reached by the court in this case? Taking its inspiration from some words in *Pegram v. Herdrich*, 530 U.S. 211 (2000), the majority elegantly skirts the boundary of ERISA preemption to avoid an outrageous outcome. Appellants allege that Mr. Cicio might well have survived, had not the plan administrator negligently denied coverage for Mr. Cicio's treatment. Under the circumstances, it seems no more than just to allow his widow's suit for malpractice to proceed in state court, as the majority does. And I certainly share in the majority's "skepticism of a line of reasoning that would draw from a 'comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans,' the elimination of protective standards of professional conduct." *Ante*, at 104 (internal citation removed).

Yet in the end I cannot reconcile the majority's holding with the Supreme Court's precedents and with the structure of ERISA itself, given those precedents. Nor do I believe that the majority opinion somehow "fixes" the problem with the ERISA caselaw. The conclusion that my colleagues have reached today is a band-aid on a gaping wound. It may provide justice to Mrs. Cicio, and I'm glad for that, but the injury that the courts have done to ERISA will not be healed until the Supreme Court reconsiders the existence of consequential damages under the statute, or Congress revisits the law to the same end.

I.

The country's leading ERISA scholar, John Langbein, has demonstrated that ERISA § 502(a), the civil remedies section, closely tracks the traditional remedies of trust law. *See* John H. Langbein, What ERISA Means by "Equitable": The Supreme Court's Trail of Error in *Russell*, *Mertens*, and *Great West*, Yale Law & Economics Research Paper No. 269 (Jan. 2003), *available at* www.ssrn.com. Under traditional precepts, an aggrieved trust beneficiary "may recover (1) for loss incurred, (2) for any profits that the trustee made in breach of trust, and (3) for any gains that would have accrued but for the breach," i.e., for consequential damages. *Id.* at 29. Trust beneficiaries may not, however, recover punitive damages. *Id.* at 59. By setting into motion the development of a body of federal trust law to govern benefit plan administration, and by preempting state laws that would add (or subtract) to the relief provided by § 502, the drafters of ERISA nicely "balanc[ed] the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

Or so Congress and ERISA beneficiaries fairly could have hoped. What they got instead was the Supreme Court's "Trail of Error," in which the Court lumped consequential and punitive damages into the misleading category of

"extracontractual relief," *see Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985), and disallowed both by dint of an anachronistic (and historically false) law/equity distinction said to be implicit in Congress's provision for "appropriate equitable relief" in § 502(a)(3). *See Mertens v. Hewitt Assocs.*, 508 U.S. 248, 255 (1993); *see generally* Langbein, Trail of Error, at 28-75, and especially 62-73. The upshot is that ERISA, despite its ambition, today generally does not "make whole" plan beneficiaries harmed by plan administrators' misconduct. *See ante* at 95, n.8, and sources there cited.

Not surprisingly, there has developed pressure on ERISA's preemption provisions, so that the states may see to it that plan beneficiaries who under a proper, trust-based reading of § 502(a) would be adequately cared for by ERISA, are otherwise protected ex ante, or compensated ex post, under state law. The Supreme Court's recent holding in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), and its discursion on "mixed" eligibility and treatment decision in *Pegram*, is evidence of that pressure. But the opportunistic attacks on preemption that may result will serve mainly to complicate ERISA and to create anomalous results. Some deserving plaintiffs will be helped out along the way, but many others will obtain no relief, and providers will increasingly have to face that very patchwork of liability risks—differing from state to state—that ERISA's preemptive scheme was meant to avoid.

Because it is not too late for the Supreme Court to retrace its Trail of Error and start over from the beginning,[1] or for

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[1] ERISA is a difficult statute, and the Supreme Court has shown admirable flexibility in its approach to the law. *See, e.g., N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995) ("[W]e have to recognize that our prior attempt to construe the phrase 'relate to' [in ERISA's express preemption section] does not give us much help drawing the line here."). The Court's

Congress to wipe the slate clean, I decline to join in Part V of the majority's opinion.

II.

A short dissent is not the place to delve deeply into the mysteries of ERISA preemption law.[2] Suffice it to say that, after a disastrous flirtation with the notion that any cause of action that was in any way connected to an ERISA contract was preempted by ERISA, the law has moved more and more in the direction of barring only those state actions which, if local law were permitted to govern, would expand (or contract) the relief available beyond that provided by § 502(a) of ERISA. *See Cal. Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc.*, 519 U.S. 316, 334-36 (1997) (Scalia, *J.*, concurring) (recognizing problems with the Court's early ERISA preemption decisions, and calling for a more open acknowledgment of the evolution that has occurred in the ERISA preemption jurisprudence); *Rush Prudential*, 122 S. Ct. at 2167 ("While independent review under [an Illinois claims-review statute] may well settle the fate of a benefit claim under a particular contract, . . . the relief ultimately available [, i.e., coverage of

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willingness to update its initial gloss on ERISA preemption is cause for hope that the Court may yet revisit its disallowance of consequential damages under § 502(a)(3).

[2] In particular, I do not deem it worthwhile to get into the vagaries of when express preemption under ERISA dictates a result, and when, additionally, complete preemption requires that the case be heard in federal court. It is enough to note that the arguments I make, if valid, require complete preemption in this case. Specifically, permitting this suit to go forward would mean allowing an "alternative enforcement mechanism" to that provided by ERISA's civil remedies section. *See Plumbing Indus. Bd. Local Union No. 1 v. E.W. Howell Co.*, 126 F.3d 61, 67 (2d Cir. 1997), quoting *N.Y. State Conference of Blue Cross & Blue Shield Plans*, 514 U.S. at 658 (1995).

the disputed medical procedure,] would still be what ERISA authorizes in a suit for benefits under [§ 502(a)]."). Even accepting this more limited—and I believe more sensible—scope of preemption, where does that leave Mrs. Cicio's suit? The answer lies in whether the suit, in its essence, is to obtain relief for the violation of rights under the terms of the ERISA plan, in which case the state action is preempted, or whether it is a suit for malpractice against a doctor (or the doctor's employer) as to which the existence of ERISA coverage is only incidental. To put it another way, if ERISA were not there, would this suit essentially be against an insurance provider for negligently failing to give the coverage contracted for, or would the suit be against a medical care provider for negligent failure to treat? Because I think that the current suit is clearly of the first sort, I regretfully conclude that it is barred.

It is, of course, possible that the insurance provider is also the medical care provider. In such cases, in which propriety of treatment and propriety of judgment as to eligibility under an ERISA plan are intertwined, I do not believe that a state-law malpractice suit would be preempted. Such a state-law action cannot be preempted, simply because the *treatment* decision was made by the same person who made the improper decision as to the *scope of coverage* under an ERISA plan. The fact that the medical malpractice and the contract misinterpretation involved the exact same error does not make the state tort action in any way dependent on a finding that the ERISA contract has been breached. It therefore would not be barred by ERISA.

There may also be situations in which it is unclear whether the plan provider is the medical provider as well (or is that provider's employer). Then too, state law may be free from ERISA preemption in ruling on whether what the plan administrator did constituted medical treatment or, what is the same thing, amounted to an employment of medical care

providers. And, if state law so determined, once again a state malpractice suit might lie.[3]

The case before us is, unfortunately, not amenable to any such interpretations. Despite the majority's admirable efforts, the facts, read most favorably to the appellant, are plain. The plan administrators—perhaps because of bad medical judgment, perhaps for other improper reasons—interpreted Mr. Cicio's ERISA-plan contract not to cover the procedure he and his treating physician sought. The treating physician, however, did not give up and in time the plan administrator relented, in part. By then it was too late.

On these facts it seems to me clear beyond peradventure a) that the plan administrators were not, in any way, acting as Mr. Cicio's doctors, b) that what they were doing was—perhaps negligently—determining the scope and coverage of an ERISA-plan contract, c) that as a result of that allegedly improper denial of coverage, Mr. Cicio was financially unable to obtain, in time, the treatment he and his treating physician continued to seek, and d) that catastrophic, consequential damages—Mr. Cicio's death—flowed from

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[3] Indeed, a suggestion could even be made that a) where a treating physical fails to attempt to treat simply *because* the plan administrator denied coverage, and b) that denial was ostensibly made on medical grounds, it may be possible for a state to find that the plan administrators *de facto* controlled the treating physician and hence were responsible—as principals—for that doctor's malpractice as agent. This approach would lead to the seeming paradox that recoveries of consequential damages against the plan administrators might be available when the plaintiff's physician foolishly forwent trying to treat after the administrators denied coverage, while such damages would be precluded when that same physician wisely continued to try to treat and stopped only because the moneys needed for treatment were not available. But the paradox is more apparent than real, since it is always the case that a person who suffers a medical maloccurrence after proper medical treatment is worse off—in terms of legal damages—than one whose medical maloccurrence was due to malpractice.

the improper misreading of the ERISA-plan coverage. Mrs. Cicio then sued for those damages. If this is not a paradigmatic suit to remedy the violation of rights under the terms of the plan, I don't know what is.

The majority tries to make much of the fact that the coverage decision was erroneously made because of a *medical error* on the plan administrator's part. That may well be, but that fact seems to me irrelevant. Indeed, its irrelevance shows why, at best, the majority opinion only band-aids a gaping wound.

Improperly erroneous coverage decisions by plan administrators can be made for any number of reasons, medical and non-medical. The result of such denials of coverage, as a practical matter, often will be, as it allegedly was in this case, the source of disastrous consequential injuries. The ERISA beneficiary gets no money and as a result suffers grievous consequential harms. Such harms are not, however, remediable injuries under ERISA, given the Supreme Court's misguided decision in *Mertens*, 508 U.S. at 255-62 (1993) (holding that "appropriate equitable relief" under ERISA § 502(a)(3) does not encompass compensatory damages). And there is no suggestion in the preemption cases that state suits based on the underlying negligence that gave rise to an erroneous coverage decision can survive under ERISA. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (holding preempted a state-law claim based on allegedly improper processing of benefits).

There is none, that is, except for the unexplained comment in *Pegram*—on which the majority puts such weight—dealing with medically based errors. But that well intentioned dicta can only make sense where the underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or

such a physician's employer, as was the case in *Pegram*.[4] Where, as here, no such relationship existed, there is no apparent reason, in state or federal law, for treating the unlawful coverage decision any differently from any other unlawful coverage decision that is *not* based on medical error.

In the end, stretching to avoid preemption in order to allow state actions for consequential damages in cases like this one, in which the wrongful coverage decision was medically based, will help a few deserving people, like Mrs. Cicio. It will, however, leave unaided all those who suffer identical consequential damages as a result of non-medically based wrongful coverage decisions. And there is nothing in ERISA theory or practice that seems to me to justify such different treatment.

III.

The majority reaches a result that I believe to be just *in this case*, and I applaud it. Since that result neither fits with the existing structure of ERISA nor—except occasionally and anecdotally—solves the problem caused by the Supreme Court's denial of consequential damages under ERISA, I respectfully dissent from Part V of the majority's opinion.

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[4] *Pegram*, of course, was not a preemption decision.

208 F. Supp. 2d 288

United States District Court,
E.D. New York.

Bonnie CICIO, Individually and as administratrix of the Estate of CARMINE CICIO, Plaintiff,

v.

VYTRA HEALTHCARE, BRENT SPEARS, M.D., Individually, and JOHN DOES, 1-8, Defendants.

No. 00-CV-3047(JS)(ETB).

Sept. 28, 2001.

ORDER ADOPTING REPORT AND RECOMMENDATION

SEYBERT, District Judge.

On June 21, 2000, Defendants moved for an order of dismissal pursuant to Fed. R. Civ. P. 12(b)(6) for failure to state a claim upon which relief may be granted. On June 28, 2000, Plaintiff moved to remand this action to the Supreme Court of the State of New York, Suffolk County, pursuant to 28 U.S.C. § 1447(c). By Order dated August 22, 2000, this Court referred the motion to Magistrate Judge E. Thomas Boyle. The magistrate judge completed his report and recommendation on March 13, 2001, recommending to the Court that the Plaintiff's motion to remand be denied and Defendants' motion to dismiss as to all counts be granted. Plaintiff filed her objections to the Report and Recommendation on March 23, 2001 and Defendants filed papers on April 17, 2001 which urge the Court to adopt the Magistrate's report.

The issues raised arise from Plaintiff's claim that defendant Vytra delayed in approving a tandem double stem cell transplant until it was too late to benefit her husband,

who died of multiple myeloma, a blood cancer, in May of 1998. After Plaintiff initiated an action in state court, wherein she alleged eighteen state causes of action,[1] the Defendants removed the case to federal court, which gave rise to the instant motions.

In his report and recommendation, the magistrate judge, applying the two-prong test for ERISA removal and preemption set forth in *Romney v. Lin*, 94 F.3d 74 (2d Cir. 1996), found that the Plaintiff's state law claims were preempted by ERISA and were within the exclusive scope of ERISA's civil enforcement provisions. *See* Report and Recommendation at 4-10. He then found that although asserted as causes of action for breach of contract, negligence and malpractice under state law, the gravamen of the complaint was an attack on benefits decisions—preempted by ERISA § 514—and, as such, could not be sustained. *Id.* at 11-16. For the reasons discussed below, the report and recommendation is adopted in its entirety, the Plaintiff's motion to remand is denied, Defendants' motion to dismiss is granted, and this case is dismissed with prejudice.

The procedural history of this case is amply set forth in Magistrate Judge Boyle's report, as are the other facts of this case. Thus, pursuant to Fed. R. Civ. P. 72(b), the Court proceeds to a *de novo* review of that "portion of the magistrate judge's disposition to which specific written objection has been made."

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[1] The Complaint alleges claims for medical malpractice, practicing medicine without a license, negligence, gross negligence, tortious interference with the physician-patient relationship, breach of fiduciary duty, misrepresentation, negligent misrepresentation, negligent supervision of employees, negligent infliction of emotional distress, intentional infliction of emotional distress, breach of contract, bad faith breach of insurance contract and deceptive acts and business practices.

In sum, Plaintiff objects to the magistrate judge's determinations that: (1) removal to federal court was proper because her claims relate to an ERISA plan and thus are preempted thereunder; and, (2) dismissal of her claims is warranted. She urges the Court to reject these findings as clearly erroneous. *See* Pltf.'s Aff. in Opp'n ¶ 2; Pltf.'s Memo. of Law at 1, 4-10. Plaintiff advances four arguments: (1) that ERISA does not apply to HMOs and utilization review; (2) that Vytra is not an ERISA plan; (3) that her state law claims arise from improper medical care and should not be construed under ERISA and/or dismissed; and, (4) that her claims against Dr. Spears and John Doe physicians should be remanded because they are not governed by ERISA. These objections are discussed below.

1. ERISA Applies to All of Plaintiff's Causes of Action

In his Report and Recommendation, the magistrate judge found that,

> Plaintiff's policy constitutes an employee welfare benefit plan within the meaning of ERISA. It was a plan established by an employer, North Fork Bank, for the purposes of providing medical benefits through the purchase of insurance. *See* 29 U.S.C. § 1002(I)(A) (definition of an "employee benefit plan").

Report and Recommendation at 8.

Plaintiff takes issue with the magistrate judge's conclusion. Plaintiff's first and second objections are based on her contention that VYTRA's health care plan is not an employee benefit plan such that it falls within the exclusive enforcement provisions of ERISA. She asserts that although Congress intended for ERISA enforcement mechanisms to provide the exclusive remedy for employee pension plans, it did not intend to have ERISA govern claims relating to HMOs, utilization review and other health-plan issues. *See* Pltf.'s Memo. at 3-4. Plaintiff argues that the courts' failure

to acknowledge the distinction between pensions plans and health care plans has led to "unfair and counter-intuitive decisions" which "strip[ ] plaintiffs of their rights." *Id.*

The Court concurs with the magistrate judge's findings and the well-reasoned authority on which he relies. Vytra's health plan is an ERISA "benefit plan" and, as such, Section 514(a) preempts Plaintiff's common law and statutory claims arising from breach of contract, bad faith breach of insurance contract, misrepresentation and negligent misrepresentation under Counts Nine, Ten, Eleven, Fifteen and Sixteen of the Complaint. *See* Report and Recommendation at 8-10. As recognized by the Supreme Court,

> ERISA's comprehensive regulation of employee welfare and pension benefit plans extends to those that provide "medical, surgical, or hospital care or benefits" for plan participants or their beneficiaries "through the purchase of insurance or otherwise." The Federal statute does not go about protecting plan participants and their beneficiaries by requiring employers to provide a given set of minimum benefits, but instead controls the administration of benefit plans.

N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 115 S. Ct. 1671, 1674 (1995).

In construing the scope of the statute, courts have recognized ERISA's reach over claims arising from a variety of medical and other employee benefit plans. *See, e.g., Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 107 S. Ct. 1542 (1987) (ERISA preemption of tort and contract claims based upon denial of disability benefits); *Zervos v. Verizon New York*, 252 F.3d 163 (2d Cir. 2001) (reviewing denial of insured plaintiff's motion for a preliminary injunction arising from an ERISA dispute over denial of experimental medical treatment); *Kolasinski v. Cigna Healthplan of CT., Inc.*, 163 F.3d 148 (2d Cir. 1998) (ERISA preemption of state law

claims arising from failure to provide insured with compensation for medical treatment); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D.N.Y. 1994) (ERISA governs claims for breach of contract, medical malpractice, wrongful death and misrepresentation based upon delaying husband's medical treatment); *Raff v. Travelers Ins. Co.*, No. 90-CV-7673, 1996 WL 137310, at *3 (S.D.N.Y. Mar. 26, 1996) (recognizing ERISA's extension over claims for breach of contract, conversion and unjust enrichment); *see also Logan v. Empire Blue Cross & Blue Shield*, 275 A.D.2d 187, 194-95, 714 N.Y.S.2d 119 (2d Dep't 2000) (tort and contract claims for denial of experimental Lyme disease treatment preempted by ERISA), *leave to appeal denied*, 96 N.Y.2d 823, 729 N.Y.S.2d 443 (2001).

Plaintiff is mistaken in her contention that "Vytra is not the ERISA" plan and in relying on *Pegram v. Herdrich*, 530 U.S. 211, 120 S. Ct. 2143, 2147 (2000). As noted by the magistrate judge, the "plan" at issue is not Vytra but the agreement between Vytra and Plaintiff's employer which sets forth the rules under which beneficiaries are entitled to benefits. This conclusion is consistent with rather than contrary to *Pegram*, *supra*, wherein the Court recognized that "[r]ules governing . . . definition of benefits, submission of claims, and resolution of disagreements over entitlement over services are the sorts of provisions that constitute a [employee benefit] plan." *Id.* at 223, 120 S. Ct. at 2151. In this case, the Plaintiff's claim arise from a health care policy administered by Vytra which set forth rules and conditions for medical care and which excluded procedures deemed by Vytra's medical director to be experimental. *See* Compl. ¶ 13 & Ex. A. at § 9.3(f).

Accordingly, the Court concurs with the magistrate judge's findings that the subject plan was an employee benefit plan within the meaning of ERISA and that the Plaintiff's claims "relate to" the plan and are thus preempted.

The Plaintiff's first and second objections are unsupported and contrary to controlling authority and are, therefore, DENIED.

2. Dismissal is Warranted because all of the claims are Preempted by ERISA Because they Arise from Administration of the Plan

As and for her third and fourth objections, Plaintiff argues that the magistrate misunderstood that, in fact, she alleges claims for improper medical care which are not preempted under ERISA. *See* Pltf.'s Memo. of Law at 6-7. Relying again on *Pegram*, *supra*, Plaintiff argues that mixed eligibility decisions such as those at issue here are not preempted. *See id.* at 8.

Plaintiff misconstrues *Pegram*, which involved a physician owned-and- operated HMO and a claim for breach of fiduciary duty within the meaning of 29 U.S.C. § 1109(a).[2] In *Pegram*, the Supreme Court noted that "pure 'eligibility decisions' turn on the plan's coverage of particular condition or medical procedure for treatment. 'Treatment decisions,' by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellations of symptoms, what is the appropriate medical response?" *Id.* at 228, 120 S. Ct. at 2154. On the facts presented, the Court considered whether the inherent conflict of interest implicated when treating

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[2] Section 1109 provides that "[a]ny person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary." 29 U.S.C. § 1109(a).

physicians derive financial benefit from withholding care automatically gives rise to a breach of fiduciary duty.

This case is distinguishable on its facts. The magistrate judge, while recognizing that a degree of medical judgment was necessarily implicated, correctly determined that the utilization review determination which gave rise to the instant Complaint involves eligibility for coverage such that Defendants' roles, including that of Dr. Spears, were administrative. *See* Report and Recommendation at 14 (citing *Pegram*).

The Plaintiff does not cite any authority for her proposition that Vytra, the plan administrator, engaged in the practice of medicine when it reached its benefits determination. The magistrate judge correctly noted the distinction between true medical malpractice claims arising from negligent treatment (Report and Recommendation at 13-14, citing *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151, 153 (10th Cir. 1995)) and claims for wrongful denial of coverage for care recommended by a treating physician which are preempted by ERISA (*id.*, citing *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 506 U.S. 1033, 113 S. Ct. 812 (1992)). In fact, in recommending dismissal of the claims, the magistrate noted two district court cases in this Circuit wherein state-law causes of action were dismissed on ERISA preemption grounds on nearly identical facts. *See id.* at 15-16 (citing *Brandon v. Aetna Servs., Inc.*, 46 F. Supp. 2d 110, 113-14 (D.Conn. 1999); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D.N.Y. 1994)).

The Court concurs with the magistrate judge's determination that all of the Plaintiff's state law claims center on Vytra's refusal to approve coverage and thus stem from an adverse benefits determination such that the claims are preempted by ERISA. The Plaintiff's third and fourth objections are, therefore, DENIED.

CONCLUSION

Having conducted a *de novo* review of Magistrate Judge Boyle's March 13, 2001 Report and Recommendation, Plaintiff's objections thereto, and all other submissions made in connection with Plaintiff's motion to remand and Defendants' motion to dismiss, the Court ADOPTS the Report and Recommendation in its entirety. Plaintiff's Motion to Remand is DENIED and Defendants' motion to dismiss is GRANTED. The Clerk of the Court is directed to close this case.

SO ORDERED.

/s/

Joanna Seybert, U.S.D.J.

Dated: Central Islip, New York
September 28, 2001

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

BONNIES CICIO, individually and as adminsitratrix of the Estate of CARMINE CICIO,

Plaintiff,

-against-

VYTRA HEALTHCARE, BRENT SPEARS, M.D., individually, and JOHN DOES, 1-18

Defendants.

CV-00-0347(JS)

REPORT AND RECOMMENDATION

Plaintiff Bonnie Cicio brings suit against Vytra Healthcare ("Vytra"), a health maintenance organization ("HMO"), Vytra's Medical Director, Dr. Brent Spears, M.D., and eight unidentified individuals ("John Does 1-8"). Defendants removed this action to federal court and now seek an order of dismissal pursuant to Federal Rule of Civil Procedure 12(b)(6) on the grounds that Plaintiff's claims are preempted by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.* Plaintiff maintains that her claims are state claims not preempted by ERISA and moves for an order of remand. The above motions were referred to the undersigned by the Honorable Joanna Seybert, United States District Judge, by order dated August 22, 2000 for a report and recommendation.

FACTS

Plaintiff was employed by North Fork Bank and received health insurance coverage for herself and her husband, Carmine Cicio, through an insurance policy purchased by North Fork Bank. Vytra administered the policy. (Compl., ¶¶ 9-11.)

According to Plaintiff, Carmine Cicio was diagnosed with multiple myeloma, a type of blood cancer, in March 1997. (*Id.*, ¶ 14.) On January 28, 1998, Dr. Edward Samuel, Mr. Cicio's oncologist, wrote Vytra requesting that Mr. Cicio receive a tandem double stem cell transplant, a treatment which Dr. Samuel described as medically necessary and possibly life-saving. (*Id.*, ¶ 15.) In a letter dated February 23, 1998 from Dr. Spears, Vytra's Medical Director, Vytra denied the request, stating that a-double stem cell transplant was an "experimental/investigational" procedure and thus not covered under Mr. Cicio's policy. (*Id.*, ¶¶ 19, 21.) Mr. Cicio, through Dr. Samuel, appealed Vytra's decision in writing on March 4, 1998, which resulted in Vytra's approval of a single stem cell transplant on March 25, 1998.[1] (*Id.*, ¶¶ 25, 29.) However, according to Plaintiff, the window of opportunity for the effectiveness of the treatment had passed by the time Vytra approved coverage for a single stem cell transplant on March 25, 1998. Mr. Cicio died approximately six weeks later.

On May 3, 2000, Plaintiff commenced this action against Defendants in the Supreme Court of the State of New York, Suffolk County alleging eighteen causes of action arising under New York state law. The theories of liability include:

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[1] Plaintiff also alleges that Dr. Samuel attempted to appeal Vytra's decision by telephone on the days immediately following his receipt of Vytra's letter denying Mr. Cicio's request. Dr. Samuel left several messages for Dr. Spears, none of which were returned. (Compl., ¶¶ 22-26.)

medical malpractice, practicing medicine without a license, negligence, gross negligence, tortious interference with the physician-patient relationship, breach of fiduciary duty, misrepresentation, negligent misrepresentation, negligent supervision of employees, negligent infliction of emotional distress, intentional infliction of emotional distress, breach of contract, bad faith breach of insurance contract, and deceptive acts and business practices under § 349 of the New York General Business Law ("GBL"). On May 30, 2000, Defendants filed a notice of removal on the basis that Plaintiff's claims relate to an "employee welfare benefit plan" as defined by ERISA. *See* 29 U.S.C. § 1002(3) (definition of "employee welfare benefit plan").

On June 21, 2000, Defendants moved for an order of dismissal pursuant to Fed. R. Civ. P. 12(b)(6) for failure to state a claim upon which relief may be granted. On June 28, 2000, Plaintiff moved to remand this action to the Supreme Court of the State of New York, Suffolk County pursuant to 28 U.S.C. § 1447(c).

DISCUSSION

I. Removal Jurisdiction

Removal jurisdiction under 28 U.S.C. § 1441 exists when a federal district court has original subject-matter jurisdiction over the plaintiff's claim. *See* 28 U.S.C. § 1441; *Lupo v. Human Affairs Int'l, Inc.*, 28 F.3d 269, 271 (2d Cir. 1994). Under 28 U.S.C. § 1447(c), a district court must remand an action to state court "[i]f at any time before final judgment it appears that the district court lacks subject-matter jurisdiction." 28 U.S.C. § 1447(c); *Lupo*, 28 F.3d at 271. A district court's assessment of subject matter jurisdiction for the purposes of determining removal jurisdiction is governed by the well-pleaded complaint rule. *See Lupo*, 28 F.3d at 272 ("[I]n addressing the substantive jurisdictional issue, the initial matter before us is the application of the well-pleaded complaint rule"); *Romney v. Lin*, 94 F.3d 74, 79 (2d Cir.

1996) ("'[i]t is long settled law that a cause of action arises under federal law only when the plaintiff's well-pleaded complaint raises issues of federal law'") (*quoting Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63, 107 S.Ct. 1542, 1546, 95 L.Ed.2d 55 (1987)).

The well-pleaded complaint rule limits the search for federal subject matter jurisdiction to "'what necessarily appears in the plaintiff's statement of his own claim in the bill or declaration, unaided by anything alleged in anticipation or avoidance of defenses which it is thought the defendant may interpose.'" *See Lupo*, 28 F.3d at 272 (*quoting Taylor v. Anderson*, 234 U.S. 74, 75-76, 34 S.Ct. 724, 725, 58 L.Ed. 1218 (1914)). Courts have also recognized an important corollary to the well-pleaded complaint rule, known as the complete preemption doctrine, which provides that, "Congress may so completely preempt a particular area that any civil complaint raising this select group of claims is necessarily federal in character." *Metropolitan Life Ins. Co.*, 481 U.S. at 63-63, 107 S.Ct. 1546.

The well-pleaded complaint rule and the complete preemption doctrine have particular relevance to actions removed to federal court by the defendant on the basis of ERISA preemption. In *Romney v. Lin*, 94 F.3d 74 (2d Cir. 1996), the Second Circuit held:

> [A] state-law cause of action arises under federal law within the meaning of 28 U.S.C. § 1331, and is removable under 28 U.S.C. § 1441, if (1) the cause of action is based on a state law that is preempted by ERISA, and (2) the cause of action is 'within the scope of the civil enforcement provisions of ERISA § 502(a)'. That is because Congress specifically intended to exert 'extraordinary preemptive power' when it adopted the detailed provisions of ERISA § 502(a).

Romney, 94 F.3d at 78 (internal citations omitted). "[P]reemption is therefore one requisite of removal jurisdiction, as well as the key to the merits." *Id.* State-law causes of action may not be removed to federal court solely on the theory of ERISA preemption. *See id.* ("Preemption alone is insufficient to support removal jurisdiction.") The second prong of the *Romney* test is that the state-law claim falls within the scope of the civil enforcement provisions of ERISA § 502(a).

Because the preemption issue also deals with the merits, we address the latter condition first.

(1) "Within the Scope of" ERISA § 502(a)

ERISA § 502(a), in relevant part, provides:

> A civil action may be brought—
>
> (1) by a participant or beneficiary
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan

29 U.S.C. § 1132(a)(1)(B). Congress intended for the civil enforcement mechanisms created under § 502(a) to be the exclusive remedy for rights guaranteed by ERISA. ERISA § 502(a) "represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Romney*, 94 F.3d at 80 (*quoting Ingersoll-Rand v. McClendon*, 498 U.S. 133, 144, 111 S.Ct. 478, 485, 112 L.Ed.2d 356 (1990) and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 42, 54, 107 S.Ct. 1549, 1556, 95 Led.2d 39 (1987)). ERISA defines an "employee welfare benefit plan" as:

> any plan, fund or program which was . . . established or maintained by an employer . . . for the purposes of

> providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . .

29 U.S.C. § 1002(1)(A). In *Romney*, the Second Circuit reaffirmed its holding in *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 10-11 (2d Cir. 1992), that common law claims for breach of contract and negligent misrepresentation to enforce an oral promise to pay pension related-benefits fell within the scope of ERISA § 502(a). *See Romney*, 94 F.3d at 80 (ERISA § 502 provides a cause of action to enforce employer contributions to ERISA plans); *Smith*, 959 F.2d at 10-11. Counts Nine and Ten of the Complaint allege that Vytra intentionally or recklessly misconstrued the terms of Mr. Cicio's policy, "knowingly decided not to perform its obligations under the Policy," and "adopted inconsistent and incorrect interpretations of the term 'medical necessity' and other terms contained in the Policy." (Compl., ¶¶ 82, 89, 90.) Also, Count Eleven alleges that Vytra made "negligent misrepresentations about the scope of coverage under the Policy." (*Id.*, ¶ 97.) Finally, Counts Fifteen and Sixteen allege that Vytra breached, in bad faith, the terms of an enforceable insurance contract "by failing to approve and provide care recommended by her treating physician as consistent with provisions of the policy and by delaying approval and provision of care recommended by her treating physician in contradiction to the contract." (*Id.*, ¶¶ 120, 124.)

It is apparent from these allegations that Plaintiff is seeking to enforce the terms of the plan and specifically those terms that deal with medical necessity and experimental procedures. However, as it has been recognized time and time again, ERISA § 502(a) provides the exclusive remedy for beneficiaries seeking to enforce the terms of an employee welfare benefit plan as defined by

ERISA. *See, e.g., Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D.N.Y. 1994) (claims for breach of contract and misrepresentation fall within the scope of § 502(a)); *Raff v. Travelers Ins. Co.*, 1996 WL 137310, at *3 (S.D.N.Y. 1996) (breach of contract, conversion, and unjust enrichment claims fall within the scope of § 502(a)). Accordingly, Plaintiff's claims for breach of contract and misrepresentation contained in Counts Nine, Ten, Eleven, Fifteen and Sixteen of the Complaint fall within the exclusive provisions of ERISA's civil enforcement scheme in § 502(a).

Relying on *Pegram v. Herdrich*, -- U.S. --, 120 S.Ct. 2143 (2000), Plaintiff argues that the claims alleged in the Complaint do not fall within the scope of § 502(a) because Vytra, as a HMO, is not a "plan" within the meaning of ERISA. In *Pegram*, the defendant HMO provided financial incentives to the physician owners as a reward for reducing the cost of patient care. The plaintiffs argued that this internal arrangement breached the fiduciary duties owed by the defendants to their subscriber patients. *See Pegram*, 120 S.Ct. at 2147. The Court clarified that:

> when employers contract with an HMO to provide benefits to employees subject to ERISA, the provisions of those documents that set up the HMO are not, as such, an ERISA plan, but the agreement between an HMO and an employer who pays the premiums may, as here, provide elements of a plan by setting out rules under which beneficiaries will be entitled to care.

Id. at 2151. Thus, an agreement between an employer and an HMO, which articulates the rules under which the beneficiaries are entitled to certain benefits, constitutes an employee welfare benefit plan within the meaning of ERISA. *See id.* ("Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a [employee welfare benefit]

plan.") However, the HMO itself, and the documents that set up the HMO do not constitute the plan. *See id.*

According to Plaintiff, her employer, North Fork Bank, purchased a health insurance policy administered by Vytra to provide health care benefits for North Fork employees. (Compl., ¶¶ 9-11.) The policy, entitled "Agreement for Comprehensive Health Services," outlined the rules and conditions under which members and beneficiaries received insurance coverage for medical care. (*See* Compl., Ex. A.) The policy expressly provided coverage for "medically necessary" services, and excludes "[a]ny procedure or service which in the judgment of Vytra's Medical Director, is experimental or is not generally recognized to be effective for a particular condition, diagnosis or body area." (*Id.*, ¶ 13 & Ex. A at § 9.3(f)).

Plaintiff's policy constitutes an employee welfare benefit plan within the meaning of ERISA. It was a plan established by an employer, North Fork Bank, for the purposes of providing medical benefits through the purchase of insurance. *See* 29 U.S.C. § 1002(1)(A) (definition of an 'employee welfare benefit plan'). Contrary to Plaintiff's arguments, the result is no different in light of *Pegram*, which reaffirmed that rules governing the definition of benefits and submission of claims qualify as an employee welfare benefit plan. *See Pegram*, 120 S.Ct. at 2151.

(2) ERISA Preemption under § 514(a)

Having determined that several of Plaintiff's state-law claims fall within the ambit of § 502(a), the court now turns to the other requirement under the *Romney* test, which examines whether state-law causes of action "relate to" an ERISA plan, thereby triggering federal preemption. *See Romney*, 94 F.3d at 78. As noted above, a finding that these causes of action fall within the scope of § 502(a) and "relate to" an ERISA plan confirms the appropriateness of removal. *See id.*

ERISA's preemption clause found in § 514(a) is intentionally broad:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

29 U.S.C. § 1144(a); *see New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 651, 115 S.Ct. 1671, 1677, 131 L.Ed.2d 695 (1995). ERISA stops short of preempting "any law of any State which regulates insurance," although even this exception is limited "by the provision that an employee benefit plan may not 'be deemed to be an insurance company or other insurer . . . or to be engaged in the business in insurance.'" *Travelers Ins. Co.* ("*Travelers*"), 514 U.S. at 651, 115 S.Ct. at 1677 (*quoting* 29 U.S.C. § 1144(b)(2)(A) & (B)). ERISA also does not preempt "any generally applicable criminal law of a State." 29 U.S.C. § 1144(b)(4).

In *Travelers*, the Court acknowledged the difficulty in construing the phrase "relate to" because "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course." *Travelers*, 514 U.S. at 655, 115 S.Ct. at 1677. Despite this difficulty, the Court explained that, "'[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan,'" and that the objectives of the ERISA statute may be used as guide in determining the scope of the state law that survives preemption. *Id.*, 514 U.S. at 656, 115 S.Ct. at 1677 (*quoting Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 (1983)).

Although the Court's analysis in *Travelers* excluded from the scope of ERISA preemption state claims that have an indirect, tenuous or remote relationship to ERISA, *Travelers* does not disturb the Court's decisions where the Court has held that "state laws providing alternative enforcement mechanisms also relate to ERISA plans, triggering pre-emption." *Id.* (*citing Ingersoll-Rand*, 498 U.S. at 142, 111 S.Ct. at 484). In the instant case, Plaintiff is attempting to enforce the health plan in a manner outside the exclusive scope of ERISA's civil enforcement scheme by alleging that Vytra failed to perform its obligations under the policy and intentionally misconstrued the terms of the policy. By circumventing § 502(a), Plaintiff triggers ERISA preemption under § 514(a). *See Kolasinski v. Cigna Healthplan of CT., Inc.*, 163 F.3d 148, 149 (2d Cir. 1998) (ERISA § 514(a) preempts common law breach of contract and unfair trade practices claims brought by a plaintiff who was seeking compensation from his insurance provider who had agreed to provide coverage for "medically necessary services"); *Saks v. Franklin Covey, Co.*, 117 F.Supp.2d 318, 330 (S.D.N.Y. 2000) ("[I]t has long been held that a plaintiff has no claim for breach of contract against a plan administrator for failing to award benefits, because such claims are squarely preempted by ERISA.")

Based on the foregoing discussion, I find that § 514(a) of ERISA preempts Plaintiff's common law or statutory claims for breach of contract, bad faith breach of insurance contract, misrepresentation and negligent misrepresentation contained in Counts Nine, Ten, Eleven, Fifteen and Sixteen of the Complaint. Therefore, Defendants have shown that a federal question exists in this action, and accordingly, this case has been properly removed. For the purposes of deciding Plaintiff's motion to remand, we do not need to determine whether the remaining counts in the Complaint also satisfy the *Romney* test. Because the court has original jurisdiction over this action, and the remaining counts arise out of the same case or controversy, the court may exercise

supplemental jurisdiction over the remaining counts, in the event that they are not pre-empted by ERISA § 514(a), an issue addressed below in the context of Defendants' Rule 12(b)(6) motion to dismiss. *See* 28 U.S.C. § 1367 (supplemental jurisdiction). Thus, for the reasons stated above, I recommend that Plaintiff's motion to remand be denied.

II. Rule 12(b)(6) Motion to Dismiss

For the purposes of Defendants' Rule 12(b)(6) motion to dismiss, the allegations of the Complaint are deemed to be true and the court "must draw all reasonable inferences in favor of the plaintiff." *Hamilton Chapter of Alpha Delta Phi, Inc. v. Hamilton College*, 128 F.3d 59, 63 (2d Cir. 1997); *Giglio v. Dunn*, 732 F.2d 1133, 1133 (2d Cir. 1984).

A. ERISA Preemption under § 514(a)

Congress intended for ERISA to regulate all aspects of employee welfare benefit programs. *Saks*, 117 F. Supp.2d at 330. As explained above, ERISA § 514(a) preempts all state laws that "relate to" an employee benefit plan, with a few statutory exceptions. As also discussed previously, Counts Nine, Ten, Eleven, Fifteen and Sixteen of the Complaint purport to create alternative theories of recovery outside the exclusive scope of ERISA's civil enforcement scheme, thereby triggering preemption under § 514(a). Accordingly, these counts should be dismissed.

Defendants argue that Plaintiff's remaining causes of action should also be dismissed on the grounds that they "relate to" an employee benefit plan and are preempted by ERISA. I now turn to a discussion of these remaining counts.

B. State-Law Claims

(1) Medical Malpractice, Practicing Medicine without a License, Tortious Interference with the Physician-Patient Relationship, Negligence, Gross Negligence, Negligent Supervision of Employees, Breach of Fiduciary Duty, Intentional Infliction of Emotional Distress, Negligent Infliction of Emotional Distress (Counts One, Two, Three, Four, Five, Six, Seven, Eight, Twelve, Thirteen, Fourteen, Eighteen)

All of the remaining claims center around Vytra's refusal to approve coverage for the treatment recommended by Mr. Cicio's treating physician and Vytra's alleged failure to render its decision in a timely manner. Briefly summarizing the nature of these claims, Count One alleges a claim for medical malpractice against Vytra. (Compl., ¶¶ 33-37) This claim alleges that Vytra failed to exercise reasonable care and provide treatment consistent with the standards of the medical profession, including the failure to adequately provide medically necessary treatment. (*Id.*) Count Four is a medical practice claim against Dr. Spears and his unnamed colleagues who allegedly failed to provide reasonable care in accordance with the ordinary medical standards. (*Id.*, ¶¶ 54-57.) Count Seven alleges that Defendants' failure to provide approval for a double cell stem transplant interfered with Mr. Cicio's relationship with his treating physician, Dr. Samuel. (*Id.*, ¶¶ 69- 76.)

Counts Two and Three allege that Vytra engaged in the unlawful practice of medicine without a license when Vytra allegedly made determinations as to the medical necessity of the requested treatment for Mr. Cicio. In Count Three, Plaintiff asserts that New York Public Health Law § 4410, which declares that "the provision of comprehensive health services directly or indirectly, by a health maintenance organization through its comprehensive health services plan

shall not be considered the practice of the profession of medicine by such organization or plan," violates the New York Constitution. (*Id.*, ¶¶ 38-53, *citing* N.Y. Pub. Health L. § 4410).

Counts Five and Six allege that all Defendants acted negligently and were grossly negligent by failing to approve coverage for the requested treatment and by failing to consider the request for treatment in a timely manner. (*Id.*, ¶¶ 58-68.) Count Twelve alleges that Vytra failed to use reasonable care in the supervision of Vytra's employees who made determinations regarding Mr. Cicio's coverage request. (*Id.*, ¶¶ 103-106.)

Count Eight alleges that Defendants breached their fiduciary duty to Mr. Cicio by failing to provide him with medically necessary care as recommend by his doctor and in a timely manner. (*Id.*, ¶¶ 77-81.) Counts Thirteen and Fourteen allege that Vytra negligently and intentionally inflicted emotional distress on the Plaintiff by failing to approve coverage for the treatment requested and by failing to make a determination within a timely manner. (*Id.*, ¶¶ 107-117.) Finally, Count Eighteen alleges that Vytra should be permanently enjoined from placing arbitrary limits on medical necessity determinations based on financial incentives. (*Id.*, ¶¶ 130-136.) All of these counts stem from an adverse benefits determination (i.e. Vytra's refusal to approve coverage for the treatment recommended by Mr. Cicio's treating physician in a timely manner).

Plaintiff argues that Vytra is a medical service provider and the decisions Vytra took were medical and not administrative. In Plaintiff's view, Vytra provided direct medical services in a role identical to that of Dr. Samuel, Mr. Cicio's oncologist. Plaintiff argues that her contentions regarding the medical nature of Vytra's determination are supported by the Court's discussion of "mixed eligibility and treatment decisions" in *Pegram*. *See Pegram*, 120 S.Ct. at 2153-2155. In *Pegram*, the Court differentiated between

"pure eligibility," "treatment," and "mixed eligibility and treatment" decisions. *See id.* Eligibility decisions turn on a plan's coverage of a particular condition while treatment decisions are choices about diagnosing and treating a patient's condition. Often times, these decisions are intertwined with each other, resulting in mixed questions of eligibility and treatment. *See id.* at 2153. ("The eligibility decision and the treatment decision were inextricably mixed, as they are in countless medical administrative decisions every day.") These distinctions are noteworthy because eligibility decisions are preempted by ERISA while treatment decisions generally are not. *Compare, e.g., Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151, 153 (10th Cir. 1995) (ERISA does not preempt medical malpractice claim challenging quality of care provided by treating physician) *with Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992) (ERISA preempts medical malpractice claim against plan administrator for wrongfully denying coverage for care recommended by treating physician).

Pegram is not controlling here, even though the complained of decision—Vytra's determination that a tandem double stem cell transplant was an experimental/ investigational procedure—may qualify as a mixed eligibility and treatment decision. *See Pegram*, 120 S.Ct. at 2154-55 (determination concerning "the experimental character of a proposed course of treatment" is a mixed eligibility and treatment decision).

In *Pegram*, the defendant HMO was a direct medical services provider. The treating physician and HMO were one in the same. *See id.* at 2147. Here, Vytra acted solely in the role of a plan administrator and was not the medical services provider. Vytra's role was limited to determining whether the proposed treatment qualified as an experimental procedure under the terms of the plan. Although Vytra's benefits determination may have involved some medical

judgment, this may be said of countless medical administrative made decisions every day. *See id.* at 2153. There is no evidence that Congress intended that these quasi-medical/administrative decisions made by a plan administrator survive ERISA preemption. Vytra's coverage determination cannot be separated or construed apart from the ERISA plan. Vytra functioned solely as a plan administrator and bore no responsibility as a provider of medical services in this action. For this reason, the challenge here does not target the quality of care but rather attacks the benefits decision that was made. This determination is preempted by ERISA. *See Saks*, 117 F.Supp.2d 318, 329-330 (ERISA preempts the plaintiff's state law claims against the plan administrator for refusing to compensate the plaintiff for "medically necessary" treatment and for violations of New York's Human Rights Law).

The Court of Appeals for the Second Circuit has not yet addressed the issue of whether state-law claims arising from an adverse mixed eligibility and treatment decision made by a plan administrator is preempted by ERISA. However, a decision from the Fifth Circuit, *Corporate Health Ins. v. Texas Dep't of Ins.* ("*Corporate Health II*"), 220 F.3d 641 (5th Cir. 2000) is the only Circuit to consider the issue. Corporate Health, an HMO, challenged a Texas law, which, *inter alia*, created an independent review procedure ("IRO") for medical necessity determinations made by an HMO. *See Corporate Health v. Texas Dep't of Ins.* ("*Corporate Health I*"), 215 F.3d 526, 534-35 (5th Cir. 2000). The court held that ERISA preempted those provisions of the Texas law that provided for an independent review of medical necessity determinations made by an HMO. *See id.* The Texas Department of Insurance filed a motion for panel rehearing and petition for rehearing *en banc*, both of which were denied. *See Corporate Health II*, 220 F.3d at 645. The court stated, "[W]e do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment."

Id. at 645. Ultimately, the court decided that the IRO provisions were plainly a state regime for reviewing benefit decisions and not a system for regulating a minimum standard of care.

Plaintiff cites to cases where medical malpractice and related claims survive ERISA preemption, but in those cases the defendant is the treating physician and/or his employer or agent. *See e.g.*, *Lupo*, 28 F.3d at 269; *Moscovitch v. Danbury Hosp.*, 25 F.Supp.2d 74 (D.Conn. 1998). Moreover, two district court cases in this circuit have dismissed state-law causes of action against plan administrators on the grounds of ERISA preemption on facts nearly identical to those alleged herein. *See Brandon v. Aetna Servs., Inc.*, 46 F.Supp.2d 110, 113-114 (D.Conn. 1999) (the plaintiff alleged a medical malpractice claim against plan administrator for failure to approve coverage for six months of psychiatric treatment where administrator had agreed to provide coverage for medically necessary services and the plaintiff's treating physician recommended such treatment); *Nealy*, 844 F.Supp. 966, 974 (S.D.N.Y. 1994) (ERISA preempted state law claims for medical malpractice, wrongful death, loss of consortium, and breach of fiduciary duties where plan administrator and medical director did not provide direct medical services). Accordingly, I recommend that the Defendants' motion to dismiss be granted as to Counts One, Two, Three, Four, Five, Six, Seven, Eight, Twelve, Thirteen, Fourteen, and Eighteen because they "relate to" an ERISA plan, and therefore are preempted by ERISA § 514.

(2) Deceptive Business Practices Claim

Plaintiff alleges in Count Seventeen that Defendants "knowingly misrepresented to Mr. Cicio and other consumers pertinent facts or policy provisions relating to insurance coverage issues" in violation of § 349 of the GBL. Plaintiff cites *Aetna U.S. Healthcare v. Maltz*, 1999 WL 285545 (S.D.N.Y. 1999), in support of her position that a

§ 349 claim for deceptive business practices survives ERISA preemption. The court disagrees. In *Maltz*, the court found that the plaintiff's allegations concerned misrepresentations about the *quality* of care plan beneficiaries would receive, the alleged misrepresentations were made in independent promotional advertisements, and the claims could be resolved without interpreting the terms of the policy. *See Maltz*, 1999 WL 285545 at *4. In the instant case, Plaintiff makes no such allegations, and is exceedingly vague concerning the alleged misrepresentations. There is no indication that they concern the quality of the care promised. To the contrary, Plaintiff claims that the misrepresentations are "relating to insurance coverage." (Compl., ¶ 128.) In light of these facts, Plaintiff's deceptive business practices claim "relate[s] to" an ERISA plan, namely Mr. Cicio's health plan, within the meaning of § 514(a) and should be pre-empted. In addition, even assuming arguendo that ERISA preemption did not apply, Plaintiff has not stated a § 349 claim under state law. *See Maltz v. Aetna U.S. Healthcare, Inc.*, 270 A.D.2d 68, 704 N.Y.S.2d 562 (2000) (HMO plan enrollees challenging HMO's promotional advertisements as a deceptive business practice following an adverse coverage determination did not state a claim under § 349). Therefore, I recommend that Defendants' motion to dismiss be granted as to this claim, also.

RECOMMENDATION

For the foregoing reasons, I recommend that Plaintiff's motion to remand be denied and Defendants' motion to dismiss as to all counts be granted.

OBJECTIONS TO THIS REPORT AND RECOMMENDATION

Any objections to this Report and Recommendation must be filed with the Clerk of the Court with a copy to the undersigned within ten (10) days of the date of entry of this report. Failure to file objections within ten (10) days will

preclude further appellate review of the District Court's order. 28 U.S.C. § 636(b)(1); Fed. R. Civ. P. 6(a), 6(e), and 72(b); *IUE AFL-CIO Pension Fund v. Herrmann*, 9 F.3d 1049, 1054 (2d Cir. 1993), *cert. denied*, 513 U.S. 822 (1994); *Frank v. Johnson*, 968 F.2d 298 (2d Cir.), *cert. denied*, 506 U.S. 1038 (1992); *Small v. Secretary of Health and Human Serv.*, 892 F.2d 15, 16 (2d Cir. 1989) (per curiam).

SO ORDERED.

Dated: March 13, 2001.
Central Islip, New York

/s/
E. Thomas Boyle
United States Magistrate Judge

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT
UNTED STATES COURTHOUSE
40 Foley Square
New York 10007

At a stated term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse, Foley Square, in the City of New York, on the 21st day of April, two thousand three.

BONNIE CICIO, individually and as Administratix of the Estate of Carmine Cicio,

Plaintiff-Appellant,

v.

Docket No. 01-9248

VYTRA HEALTHCARE and BRENT SPEARS, M.D.

Defendants-Appellees,

JOHN DOES 1-8,

Defendants.

A petition for panel rehearing and a petition for rehearing en banc having been filed from an opinion herein by appellees, Vytra Healthcare and Brent Spears, M.D.

Upon consideration by the panel that decided the appeal, it is ordered that said petition for rehearing is **DENIED**.

It is further noted that the petitions for rehearing en banc have been transmitted to the judges for the Court in regular active service and to any other judge that heard the appeal and that no such judge has requested that a vote be taken thereon.

FOR THE COURT
ROSEANN B.
MACKECHNIE

By: /s/
Arthur Heller,
Administrative Attorney

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

MANDATE

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse, Foley Square, in the City of New York, on the 12th day of March, two thousand and three.

Before: Hon. Guido Calabresi,
Hon. Robert D. Sack,
Hon. B. D. Parker, Jr.,
Circuit Judges

Docket No. 01-9248

BONNIE CICIO, individually and as Administratix of the Estate of Carmine Cicio,

Plaintiff-Appellant,

v.

JOHN DOES 1-8,

Defendants,

VYTRA HEALTHCARE and BRENT SPEARS, M.D.

Defendants-Appellees.

Appeal from the United States District Court for the Eastern District of New York.

This cause came on to be heard on the transcript of record from the United States District Court for the Eastern District of New York and was argued by counsel.

On consideration whereof, it is hereby ORDERED, ADJUGED and DECREED that the judgment of said district court be and it hereby is AFFIRMED in part, VACATED in part and REMANDED for further proceedings in accordance with the amended opinion of this Court.

FOR THE COURT
ROSEANN B.
MACKECHNIE, Clerk

By: /s/
Arthur Heller,
Administrative Attorney

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

BONNIE CICIO, individually and as Administratix of the Estate of Carmine CICIO,

Plaintiff,

-against-

JUDGMENT
CV 00-3047 (JS)

VYTRA HEALTHCARE, BRENT SPEARS, M.D., Individually, and JOHN DOES 1-8

Defendants.

An Order of Hon. Joanna Seybert, United States District Judge, having been filed on September 28, 2001, adopting in its entirety, the Report and Recommendation of Magistrate Judge E. Thomas Boyle, dated March 13, 2001; and denying plaintiff's motion to remand and, granting defendants motion to dismiss, it is

ORDERED AND ADJUDGED that plaintiff take nothing of the defendants; that the Report and Recommnedation of United States Magistrate Judge E. Thomas Boyle is adopted in its entirety; that plaintiff's motion to remand is denied; and that the defendants motion to dismiss is granted.

ROBERT C. HEINEMANN
Clerk of the Court

By: /s/
Deputy Clerk

Dated: Central Islip, NewYork
October 4, 2001

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

BONNIE CICIO, individually and as administratix of the Estate of CARMINE CICIO,

Plaintiff,

v.

VYTRA HEALTHCARE and BRENT SPEARS, M.D., Individually, and JOHN DOES 1-8

Defendants.

Docket No.: CV 00-3047 (JS)

NOTICE OF APPEAL

Notice if hereby given that plaintiff, Bonnie Cicio, individually and as administratix of the Estate of Carmine Cicio, hereby appeals to the United States Court of Appeals for the Second Circuit from the judgment dated September 28, 2001, entered on the docket on October 4, 2001 and signed by the Honorable Joanna Seybert, entering judgment in favor of the defendants against the plaintiff.

Dated: Mineola, New York
October 26, 2001

/s/

DAVID L. TRUEMAN
Attorney for Plaintiff
221 Mineola Boulevard
Mineola, New York 11501

JOEL J. ZIEGLER
Attorney for Plaintiff
199 East Main Street
Box 829
Smithtown, New York 11787

Agreement for Comprehensive Health Services

This is your Subscriber Agreement with Vytra Healthcare Long Island, Inc. It is issued to the subscriber named on the Vytra identification card. It entitles the Subscriber (and Eligible Dependents if the Subscriber has selected family coverage) to comprehensive health services provided by this agreement. Coverage begins on the effective date stated on the identification card.

* * *

Article I
Definitions

* * *

Section 1.20

"Medically Necessary" means a determination made in accordance with well-established professional medical standards that Vytra Services are:

(i) consistent with an essential for diagnosis and treatment of the member's condition, disease, ailment or injury;

(ii) the most appropriate supply or level of service which can be provided safely;

(iii) provided for the diagnosis or the direct care treatment of the Member's condition, disease, ailment or injury; and

(iv) when applied to hospitalization, means further that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition and that the Member cannot receive safe or adequate care as an outpatient.

* * *

Article III
Medical and Health Services

* * *

Section 3.5
Limitations

Health and medical services from a Participating Physician shall be limited as follows:

(a) Vytra shall provide only Medically Necessary Vytra Services which are provided, directed, authorized or arranged by a Primary Care Physician. As special in this Agreement, certain Vytra Services from a Non-Participating Physician also require Prior Approval.

(b) Exclusions set forth in ARTICLE IX.

* * *

Article IX
Limitations and Exclusions

* * *

Section 9.3
Types of Non-Covered Services

Vytra Services shall not include and Vytra shall have no obligation for the following services or conditions:

(a) Health, medical and Hospital services for military services connected disabilities which are an obligation of the Veterans Administration and for which adequate facilities are available in this area;

(b) Physical exams and diagnostic testing for certification of health not required by a Physician for the provision of Vytra Services, such as pre-employment, pre-marital, licensure, insurance, camp, school, adoption, and similar exams;

(c) Procedures for the purpose of reversing voluntary sterilizations;

(d) In Vitro fertilization, artificial insemination or other artificial means of conception;

(e) Hospital, surgical, laboratory and other expenses incurred by a Non-Member donor for an authorized transplant to a Member;

(f) Any procedure or service which, in the judgment of Vytra's Medical Director, is experimental or is not generally recognized to be effective for a particular condition, diagnosis, or body area;

(g) Any Inpatient Hospital procedure or service which has not been approved by the NYS Health Department;

(h) External prosthetics;

(i) Durable medical equipment;

(j) Care or services in connection with the detection and correction by manual or mechanical means of structural imbalance, removing nerve interference and distortion or subluxation in the human body for the purpose of the effects thereof, where such interference is the result of or related to distortion or misalignment or subluxation of the vertebral column;

(k) Hearing aids;

(l) Care or services in connection with routine care of the feet, including services in connection with corns, callauses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;

(m) Cosmetic, plastic or reconstructive surgery, except:

(i) when following surgery for treatment of trauma, infection, or other disease, or

(ii) for treatment of a congentical disease or anomaly which results in a functional defect in an Eligible Dependent child.

(n) Transsexual operations;

(o) Non-emergency transportation, such as that between facilities or to the Member's home;

(p) Drugs, medicines and disposable supplies as not administered at a Hospital or office of a Participating Physician, or not customarily provided by and administered as part of a Home Health Service;

(q) Services within, and customarily provided as, the practice of dentistry, including temporomandibular joint dysfunction. However, Vytra Services will be provided under this Agreement in connection with accidental injury to sound natural teeth within twelve months of the accident;

(r) Hearing test for members over age 17 to determine need for hearing correction;

(s) Eye tests for members over age 17 to determine need for vision correction;

(t) Autologous blood donation;

(u) Personal or comfort items;

(v) Any other limitation or exclusion stated in this Agreement.

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No. 03-69

IN THE

Supreme Court of the United States

VYTRA HEALTHCARE AND BRENT SPEARS, M.D.,

Petitioners,

v.

BONNIE CICIO,

Respondent.

On Petition for a Writ of Certiorari
to the United States Court of
Appeals for the Second Circuit

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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ARGUMENT

POINT I

THIS COURT HAS ESTABLISHED A NEW ERISA JURISPRUDENCE

In *Pegram v. Herdrich*, 530 U.S. 211 (2000), this Court established a new ERISA jurisprudence while considering whether HMOs and capitated medical groups were fiduciaries under ERISA. In the case, this Court identified the three types of decisions made within the health care context: "pure eligibility," where a decision pertains solely to ascertaining whether a condition is covered pursuant to the policy, "pure treatment," where a physician engages in medical conduct, including diagnosis and treatment of a patient, and "mixed eligibility and treatment" decisions. These latter determinations are medical decisions made within the context of pre-authorization and have been defined by this Court in *Pegram* as including

> physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities . . . ; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition. *Id.* at 230.

In *Pegram* this Court ruled that HMOs were not considered to be fiduciaries and stated that claims implicating mixed eligibility and treatment decisions were not those made by a fiduciary, were preempted by ERISA, and allegations of negligence related to these determinations should be pursued under state medical malpractice law. However, although *Pegram* was a case pertaining to an alleged breach of

fiduciary duty involving a capitated medical group, this Court apparently has subsequently indicated that the new jurisprudence applies to all mixed eligibility and treatment decision-making regardless of the form of the entity making that determination. In *U.S. Healthcare Systems Systems of Pennsylvania, Inc., v. Pennsylvania Hospital Insurance Co., 530 U.S. 1241 (2000)*, this Court granted certiorari in the case of *Pappas v. Asbel,* 724 A.2d 889 (1998) *("Pappas I")*, where the Pennsylvania Supreme Court determined that an HMO's delay in providing authorization for a patient to receive emergency neurological treatment resulting in the patient's quadriplegia was negligent. This Court vacated the judgment of the Court and remanded the case to that court for "further consideration in light of *Pegram v. Herdrich.*" *U.S. Healthcare Systems* at 889.

It can only be assumed that this Court intended for the Pennsylvania Supreme Court to consider *Pappas I* in light of the new "mixed eligibility and treatment decision" language in *Pegram* since there was no issue of fiduciary duty in *Pappas I.* It seems logical to conclude that instead of limiting the scope of *Pegram* by refusing to review the case, this Court expanded the parameters of *Pegram* with its vacatur and instructions for review in *U.S. Healthcare Systems*, thereby fashioning a jurisprudence that applied to all types of managed care entities making the determinations this Court identified as "mixed eligibility and treatment."

POINT II

THERE IS NO CONFUSION WHETHER ERISA PREEMPTS MIXED ELIGIBILITY AND TREATMENT DECISIONS

The thrust of the petitioners' argument is that there has been confusion in the courts regarding whether, after *Pegram*, ERISA preempts state law claims involving medically based eligibility determinations. Despite the petitioners' contentions, courts have not only not been confused but have, almost uniformly, accepted both this Court's jurisprudence espoused in *Pegram v. Herdrich* and the unarticulated principle from *U.S. Healthcare Systems* that the tripartite jurisprudence applies to HMOs and managed care entities regardless of their structure.

A. Courts Have Correctly Applied *Pegram*.

Courts which have considered cases where *Pegram* might apply have, with one exception, correctly applied this Court's jurisprudence. Although the petitioners would like this Court to believe otherwise, all the cases they mention, with this exception, have approvingly cited *Pegram* and have correctly decided claims intersecting with the jurisprudence.

1. Courts Have Consistently Correctly Applied *Pegram* To Claims Related To Utilization Review And Mixed Eligibility And Treatment Decisions.

Claims related to utilization review and the applicability of *Pegram* have been addressed by various courts. There is uniformity among the courts that *Pegram* now defines a new category which applies to claims alleging wrongful denials of physician recommended treatment. And all the courts, with one exception, have drawn the correct conclusions from the acceptance of *Pegram* and applied this case both in the

contexts of U.S.C. § 1132(a)(1)(B), (ERISA § 502(a)(1)(B)) and U.S.C. § 1144 (ERISA § 514)).

The Second Circuit, in the case at bar, applied this Court's new tripartite jurisprudence and identified that the HMO and its medical director were making mixed eligibility and treatment decisions when they made two medical decisions related to the requested treatment for the decedent's multiple myeloma: the first identified the treatment as experimental, while in the second, the company substituted its medical judgment for that of Mr. Cicio's doctor, recommending that Mr. Cicio only receive a single stem cell transplant. In reversing in part, the Court ruled that mixed eligibility and treatment decision making does not lead to either complete preemption pursuant to ERISA § 502(a) or § 514.

In *Land v. CIGNA Healthcare of Florida*, 2003 U.S. App. LEXIS 15080 (11th Cir. July 30, 2003), the Eleventh Circuit Court of Appeals ruled consistent with Pegram and approvingly cited the Second Circuit Court of Appeals' decision in *Cicio*. In *Land*, the plaintiff had developed an infection in his hand which his physicians determined required in-hospital treatment. The CIGNA approval nurse, upon review of the admission, determined that the infection was not sufficiently severe to warrant hospitalization and decided that the intravenous antibiotic treatment should be provided on an out-patient basis. By the following week the plaintiff's condition had worsened considerably and ultimately resulted in amputation of his finger.

The plaintiff filed suit in state court alleging that the defendant was negligent in the care and treatment of his infection. The defendant removed the case to federal district court where it was dismissed because the court considered the claims completely preempted by ERISA. The plaintiff appealed and the Eleventh Circuit Court of Appeals reversed, utilizing this Court's jurisprudence in *Pegram*. The Circuit

Court determined that the nurse "'made a patient-specific prescription of appropriate treatment by denying one treatment and authorizing another.' *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003)." *Land* at 15.

The Court, citing this Court's ruling in *Pegram*, determined that the plaintiff's claims were about mixed eligibility and treatment decisions and were therefore not preempted by ERISA § 502(a), thus failing to provide the federal court with jurisdiction.

> Having determined that Land's malpractice claims were not based upon a pure eligibility decision, but rather upon a mixed decision of eligibility and treatment, we must consider whether mixed decision claims are claims "to recover benefits" under section 502(a)(1)(B) and therefore completely preempted. Once again, we find the reasoning of Pegram persuasive. In reaching its conclusion that an HMO does not act as a fiduciary when it makes a mixed eligibility and treatment decision, the Court reiterated its prior holding "that, in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." Id. at 237. The Court therefore expressed strong doubt that Congress intended to federalize and preempt state law malpractice claims by converting them to fiduciary claims under section 502(a)(2) or to "apply[] an ERISA standard of reasonable medical skill." n4 Id. at 236. In our view, it makes little sense to believe that Congress did not intend to federalize malpractice claims under section 502(a)(2), but intended to do so under section 502(a)(1)(B). *Land* at 16-17.

In *Isaac v. Seabury & Smith* et al., 2002 U.S. Dist. LEXIS 12413 (S.D. Ind. July 5, 2002), the Indianapolis District Court also found that, consistent with the reasoning in *Pegram*, claims that related to mixed eligibility and treatment decisions were not preempted by ERISA and provided the court with no jurisdiction pursuant to ERISA § 502(a). In Isaac, the decedent, who participated in a fee-for-service health plan, contracted leukemia for which her oncologist requested a bone marrow transplant from an appropriate donor. Although the initial request was denied because the company stated it was not a covered expense under the plan, on appeal approval was given; tragically, the patient died before any transplant could occur.

The decedent's representative filed suit in Indiana state court and the defendants removed the case to the Southern District of Indiana, Indianapolis Division, arguing that all the claims should be completely preempted by ERISA and dismissed. The court analyzed the claim based on the tripartite distinction utilized in *Pegram* and ruled that it was a "mixed eligibility and treatment decision" not preempted by ERISA § 502(a).

The court also identified that the new jurisprudence applied to all such mixed eligibility and treatment decisions, regardless of the form of the decision-maker:

> In view of the Court's outline, we think it evident that the decisions at issue in this case come under the heading of mixed decisions of eligibility and treatment. Pursuant to determinations made by physicians -- "a board certified oncologist" in the first instance, and Dr. Sheila Donnelly in the second -- Seabury & Smith made two decisions: one denied Ms. Ambrugey coverage because the

> requested transplant procedure was not "medically necessary"; the second countermanded the first -- in effect, finding it to be within the bounds of "medical necessity" -- and gave "conditional approval" for the operation. Both decisions manifestly involved a question of coverage/eligibility – whether the costs of the bone marrow transplant operation would be covered or (essentially the same thing) whether Ms. Ambrugey was eligible for a transplant -- and a treatment decision – whether a transplant was medically necessary. *Id.* at 18.

The court also stated that:

> We see no clear distinction between a "quasi-medical/administrative decision" and a "mixed decision of eligibility and treatment." *Id.* at 25-26.

The two state courts that have considered ERISA § 514 preemption in relation to claims of wrongful denials of care in the utilization review process both found hat ERISA § 514 did not provide a defense to the claims. ....In *Pappas v. Asbel,* 564 Pa. 407 (2001) *cert. denied sub nom U. S. Healthcare Sys. Of Pa. Inc. v. Pa. Hosp. Ins. Co.*, 536 U.S. 938 (2002) ("*Pappas II*"), the Pennsylvania Supreme Court affirmed its prior decision of negligence by the HMO in the pre-certification process, and, in so doing, utilized this Court's tripartite structure. The court first noted that it was irrelevant who was making mixed eligibility and treatment decisions:

> The HMO in *Pegram* was owned by its physicians. U.S. Healthcare contracts with independent physicians to provide services. Pegram's result was based on the nature of the HMO's decision, not on the structure of the HMO making it. *Pegram*, 530 U.S. at 229, 120 S. Ct. at

2155. Further, **the Supreme Court's holding was all-inclusive as to HMOs. Id. Thus, the difference in organization between the HMO in Pegram and U.S. Healthcare is not relevant to this analysis.** [Emphasis added] *Id.* at 1094.

Furthermore, the court stated that:

While Travelers and Pegram deal with different aspects of ERISA, for our present purposes, they share common ground. Travelers instructs that ERISA does not preempt state law that regulates the provision of adequate medical treatment. Pegram instructs that an HMO's mixed eligibility and treatment decision implicates a state law claim for medical malpractice, not an ERISA cause of action for fiduciary breach. **Thus, if Haverford's third party claim against U.S. Healthcare arose out of a mixed decision, it is, according to Pegram, subject to state medical malpractice law, which is what Haverford asserted. Moreover, under Travelers, it is not preempted by ERISA.** [Emphasis added] *Id.* at 1095.

In affirming its decision, the court ruled that the defendant had made mixed eligibility and treatment decisions which were not preempted by ERISA:.

In our view, the undisputed facts in this case, and the inferences drawn from them, establish the sort of mixed eligibility and treatment decision that Pegram discussed. Dr. Leibowitz, U.S. Healthcare's physician, reviewed Pappas' case, and rejected another medical doctor's opinion based on his clinical judgment that Pappas needed to be referred to Jefferson for

> treatment of a medical emergency. Instead of referring Pappas to Jefferson, a non-HMO hospital, as Dr. Dickter recommended, Dr. Leibowitz referred Pappas to one of three other facilities for medical care. He did not, in the Supreme Court's words, only make a "simple yes or no" decision as to whether Pappas' condition was covered; it clearly was. Rather, Dr Leibowitz also determined where and, under the circumstances, when Pappas' epidural abscess would be treated. **His was a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed, as Pegram teaches, through state medical malpractice law. This law as Travelers teaches, is not preempted by ERISA.** [Emphases added] *Id.* at 1096.

And in *Eid v. Duke*, 816 A.2d 844 (Md. 2003), the plaintiff alleged that the benefits administrator of a disability plan had notified him that he had to return to work and this caused him to be injured. However, the administrator had made no medical determination and the Maryland Court of Appeals ruled that the claim was preempted by ERISA. The Court, in approvingly citing *Pegram,* noted that "the issue of preemption is inextricably bound up with the availability of a traditional medical malpractice claim under state law." *Id.* at 852. This is, indeed, correct, since the viability of the defense of ERISA § 514 is clearly fact-dependent and related to medical decision-making.

2. The Cases The Petitioners Cite Correctly Utilized Pegram And Ruled Consistent With This Court's Jurisprudence.

The petitioners, in arguing that there is confusion among the courts, actually present cases which have correctly adopted the reasoning in *Pegram* and have ruled accordingly. In *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 366 (3d Cir. 2001), the Third Circuit considered the case of whether the failure to provide approval for out-of-network care was negligent resulting in harm to the patient. In making its determination that the consideration of in- versus out-of-network providers was a purely administrative function and not preempted by ERISA, the Court referenced *Pegram* approvingly:

> The recent Supreme Court decision in *Pegram v. Herdrich,* 530 U.S. 211, 120 S. Ct. 2143, 147 L. Ed. 2d 164 (2000), suggests preferable terminology. Although that case concerned fiduciary acts under ERISA and not preemption, the distinction made there between "eligibility decisions," which "turn on the plan's coverage of a particular condition or medical procedure for its treatment," and "treatment decisions," which are choices in "diagnosing and treating a patent's [sic] condition," 120 S. Ct. at 2154, is equally applicable for complete preemption analysis. Regardless of the language used, the ultimate distinction to make for purposes of complete preemption is whether the claim challenges the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted, or the quality of the medical treatment performed, which may be the subject of a state action. *Id.* at 273.

Furthermore, the Court stated that:

> In the case before us, as we note above, Pryzbowski's claims against U.S. Healthcare are limited to its delay in approving benefits, conduct falling squarely within administrative function. A holding that Pryzbowski's claims against U.S. Healthcare are not completely preempted would open the door for legal challenges to core managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists), which the Supreme Court eschewed in *Pegram*. Cf. 120 S. Ct. at 2156-57 (rejecting claims attacking financial incentives behind HMO structure, in light of congressional policy of promoting HMOs). *Id.* at 275.

Likewise, in *Marks v. Watters,* 322 F.3d 316 (4th Cir. 2003), the Fourth Circuit Court of Appeals correctly applied the principles of *Pegram* and found the claims preempted. In Marks, the representative of the decedent sought damages alleging that the decedent, who had committed suicide, had not been properly treated. In addition to suing, among others, the physicians and the hospital, the plaintiff brought an action against Mainstay, the managed care entity. Mainstay removed the case to federal court claiming that the determinations in the case were completely preempted because they were not mixed eligibility and treatment decisions.

The Fourth Circuit agreed; in arriving at this decision the Court identified that:

> Under the teaching of *Pegram*, when an HMO diagnoses and treats a patient's condition with an appropriate medical response, even if it is at the same time making an eligibility determination, it

> does not act as a fiduciary under ERISA because the mixed eligibility and treatment decisions as a practical matter reduce to the stuff of State malpractice claims and not to traditional breach of fiduciary claims. *Id.* at 324.

The petitioner's quote from this case notwithstanding, it is clear that the Fourth Circuit approvingly cited *Pegram*. Ultimately, the Court dismissed the claims because it identified that the managed care entity made no mixed eligibility and treatment decision because it had made no medical necessity decision.

It is to be noted that although the petitioners cite the Third Circuit decision in *Pryzbowski* and the Fourth Circuit's decision in Marks as supporting alternative interpretations of *Pegram*, the Eleventh Circuit in Land identified that both Circuit courts have approvingly cited *Pegram*:

> We find additional support for our holding in decisions of the Fourth and Third Circuits, which cited *Pegram* with approval, but nevertheless concluded that the plaintiffs' claims were preempted. See *Marks v. Watters*, 322 F.3d 316, 324, 327 (4th Cir. 2003) (recognizing Pegram's teaching that "mixed eligibility and treatment decisions as a practical matter reduce to the stuff of State malpractice claims and not to traditional breach of fiduciary duty claims," but determining that the plaintiff's HMO did not make a treatment determination when the decision to release him from psychiatric care was made solely by his physician and the HMO case manager had no input in that decision); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 274 (3d Cir. 2001) (citing *Pegram* with approval and reiterating the validity of its prior holdings that

> state law claims are not preempted when "the HMO ... assumes the dual role of an administrator of benefits and a provider of medical services," but finding that the plaintiff's claims "were limited to [the HMO's] delay in approving benefits, conduct falling squarely within [the] administrative function"). *Land* at 20-21.

3. The Defendants Cite Cases That Are Not Relevant.

The petitioners also cite outdated or irrelevant cases in support of their position. First, although the petitioners cite pre-*Pegram* cases these decisions are no longer relevant and they maintain no precedential value.

Other cases the petitioners cite are irrelevant. In *Caffey v. UNUM Life Ins. Co.*, 302 F.3d 576 (6th Cir. 2002), as the petitioners acknowledge, "the court did not specifically discuss *Pegram*." Petitioner's Memorandum of Law at 14. Thus, nothing can be gleaned from case that did not address *Pegram* and its jurisprudence. And in *Howard v Coventry Health Care of Iowa, Inc.*, 293 F.3d 442 (8th Cir. 2002), the defendants made a determination regarding the use of in- and out-of-network providers, a determination that has nothing to do with the type of medical decision making identified in *Pegram*.

B. There Is Only One Case That May, In Some Manner, Partially Conflict With The *Pegram* Jurisprudence.

There is only one court which has failed to rule consistent with *Pegram* although citing *Pegram* and its jurisprudence approvingly. In *Roark v. Humana, Inc.,* 307 F.3d 298 (5th Cir. 2002), *petition for cert. filed*, 71 U.S.L.W. 3791 (U.S. June 20 2003) (No. 02-1826), and *petition for cert. filed sub nom. Aetna Health Inc. v. Davila,* – U.S.L.W. – (U.S. June 20, 2003) (No. 02-1845), the Fifth Circuit Court of Appeals ruled on a number of district court cases which had found preemption. The Court, in citing to *Pegram* identified that the "mixed eligibility and treatment" language in *Pegram*

> gives further reason to doubt that ERISA preempts medical malpractice claims such as the Roarks'. In holding that the plaintiff did not state a claim under § 502(a)(2), the Court, 530 U.S. at 236-37, expressed disbelief that ERISA preempts such claims. *Id.* at 41.

Despite its support of altering ERISA jurisprudence in the Fifth Circuit, the Court felt constrained by its prior holding in *Corcoran* and affirmed the dismissal of the Roarks' claims. The Court provided a mandate for the entire Fifth Circuit when it wrote:

> If we were writing on a clean slate, or deciding this en banc, the Roarks would have a strong case against ERISA preemption. But, as a panel we are bound by Corcoran. Id. at 41-42.

However, despite the panel's approving citation of *Pegram*, there was no *en banc* review of the case.

Thus, in reviewing all the cases, it is clear that the petitioner's position that there is great confusion is incorrect. Indeed, there is considerable uniformity of opinion among the courts that the new jurisprudence in ERISA applies to claims of mixed eligibility and treatment decision making and that these claims should be treated under state medical malpractice law. Indeed, only one court has failed to correctly decide a matter pursuant to *Pegram's* jurisprudence; however, that court correctly identified *Pegram's* applicability. The respondent argues, accordingly, that there is no confusion among the courts and this Court's intervention is unnecessary.

POINT III

CONGRESS HAS FAILED TO RESOLVE THE ISSUE IN THIS CASE AND THIS COURT SHOULD NOT LEGISLATE FOR CONGRESS

It is an established principle that courts should not legislate where Congress has failed to act. As Justice Rehnquist has commented about Congress' failure to act in *Bob Jones University v. United States,* 461 U.S. 574, 622 (1983): "Whatever the reasons for the failure, this Court should not legislate for Congress."

Congress has repeatedly attempted to resolve the issue of ERISA's impact on lawsuits against managed care entities. And Congress has repeatedly failed to resolve this issue. According to its own principles, this Court should not legislate for Congress.

CONCLUSION

For these reasons, the respondent respectfully requests that the writ of certiorari be denied.

Respectfully submitted,

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On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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This petition asks the Court to clarify whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, preempts state law claims challenging a non-treating physician's alleged medical judgment used in determining eligibility for coverage under an employee benefit plan. As demonstrated in the petition (Pet. 9-18), there is considerable confusion about this important federal question: Although prior to *Pegram v. Herdrich*, 530 U.S. 211 (2000), at least seven federal courts of appeals had held that ERISA preempts such state law claims, in the wake of *Pegram*, the lower courts have divided into four diverging camps on this issue; and the United States has added to the confusion by publishing its view that, contrary to the decision below, *Pegram* should not be read to countenance such state law claims. As further demonstrated in the petition (Pet. 13, 17-18, 18-22), the extant confusion is having deleterious effects on benefit plans and their participants, and numerous commentators have urged the Court to resolve promptly this tremendously important federal question.

Events occurring since this petition was filed have only confirmed the need for this Court's immediate intervention. Two additional federal circuits have now considered this preemption question and have decided it in opposite ways. *Compare Land v. Cigna Healthcare of Fla.*, 339 F.3d 1286 (11th Cir. 2003) (no preemption), *with Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138 (9th Cir. 2003) (finding preemption). In addition, the Clerk's Office has consolidated this petition with four other petitions raising the same preemption issue, although one petition was recently dismissed by stipulation of the parties. *See Roark v. Humana Inc.*, No. 02-1826 ("*Roark*"), *dismissed by stipulation of parties* (Sept. 18, 2003); *Aetna Health, Inc. v. Davila*, No. 02-1845 ("*Davila*"); *Conover v. Aetna US Healthcare Inc.*, No. 02-1864 ("*Conover*"); *Cigna HealthCare of Texas, Inc. v. Calad*, No. 03-83 ("*Calad*"). A wide variety of interested persons—including 15 state attorneys general, the American

Medical Association, AARP, the American Association of Health Plans, Inc., the U.S. Chamber of Commerce, the American Benefits Council, and the National Association of Manufacturers—have urged the Court to grant one of these petitions and resolve the split among the lower courts. *See* Reply App. 1a-13a (appendix attached hereto, reprinting relevant excerpts of *amici* briefs associated with other petitions for the Court's convenience); Br. of *amici* AAHP 5.

Respondent does not dispute that the petition presents an important federal question and even concedes the conflict between the Second and Fifth Circuits. Ignoring both the acknowledgment by the court below that its decision conflicts with a Third Circuit decision and the contrary views of the United States, however, respondent contends that there is no widespread confusion necessitating this Court's review. Respondent's opposition is without merit.

I. RESPONDENT WRONGLY ASSERTS THAT THERE IS NO CONFUSION ABOUT WHETHER ERISA PREEMPTS STATE LAW CLAIMS CHALLENGING MEDICALLY-BASED ELIGIBILITY DETERMINATIONS.

Respondent's principal argument is that *Pegram* established some "new ERISA jurisprudence" relating to preemption that has been almost uniformly accepted and applied. This argument is flawed at every turn.

First, contrary to respondent's argument (Opp'n 1-2), neither *Pegram* nor *U.S. Healthcare Systems v. Pennsylvania Hospital Insurance Co.*, 530 U.S. 1241 (2000), establishes any new ERISA preemption rules. *Pegram* twice expressly declined to address ERISA preemption, both with respect to the fiduciary duty issue before the Court in that case and with respect to the benefits eligibility question at issue here. *Pegram*, 530 U.S. at 229 n.9 (declining to consider preemption from benefits claim); *id.* at 236-37 (declining to consider preemption from fiduciary duty claim). Moreover,

the Court's summary reconsideration order in *U.S. Healthcare Systems*—which merely vacated and remanded for further consideration in light of *Pegram*—did not establish any new ERISA rules, as such orders are "not a 'final determination on the merits,'" *Tyler v. Cain*, 533 U.S. 656, 666 n.6 (2001) (quoting *Henry v. Rock Hill*, 376 U.S. 776, 777 (1964) (*per curiam*)), and have no precedential value. *See* R. Stern & E. Gressman, SUPREME COURT PRACTICE 317-20 (8th ed. 2002).

Second, respondent misses the point entirely in suggesting (Opp'n 3-13) that the lower courts have almost uniformly accepted *Pegram*. The issue is not one of acceptance; inferior courts are *required* to do that. The issue is one of understanding and consistently applying *Pegram* in the context of state law claims challenging medically-based eligibility determinations. On this question—which is the question presented for review—the courts and the Executive Branch are hopelessly confused and in substantial disagreement.

The Second Circuit's decision below, which expressly acknowledges a conflict among the courts (Pet. App. 26a-27a, 31a-32a), the publications of numerous legal commentators describing the broad judicial conflict (Pet. 17-18), and the multiple briefs of *amici* urging the Court to resolve the conflict (Reply App. 1a-13a), amply demonstrate the deep judicial conflict. But any careful reading of the various lower court decisions clearly demonstrates the confusion and disagreement that has arisen in *Pegram*'s wake. As respondent inconsistently admits (Opp'n 14), the court below, the Pennsylvania Supreme Court, and the Eleventh Circuit—in a case decided after this petition was filed—have all concluded that state law claims challenging medically-based eligibility determinations are not preempted by either § 502 or § 514 of ERISA, while the Fifth Circuit has held that such claims are preempted by § 514—but not by § 502—of ERISA. *See Land v. Cigna Healthcare of Fla.*, 339 F.3d 1286, 1292-93 (11th Cir. 2003); *Roark v. Humana, Inc.*, 307

F.3d 298, 315 (5th Cir. 2002); *Pappas v. Asbel*, 768 A.2d 1089, 1095-96 (Pa. 2001), *cert. denied sub nom. U.S Health Care Sys. of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 536 U.S. 938 (2002). While respondent attempts to minimize this conflict by suggesting that the Fifth Circuit may reconsider its decision (Opp'n 14), the *en banc* court has already denied rehearing. Indeed, convinced of the finality of the Fifth Circuit precedent, the Attorney General of the State of Texas has asked this Court to resolve the "direct conflict" between the Fifth Circuit's *Roark* decision and the Second Circuit's decision here. Reply App. 10a.

But the conflict goes much further. In contrast to both the Fifth Circuit's partial-preemption approach and the approach of those courts finding no preemption under either § 502 or § 514 of ERISA, the Third, Sixth, Eighth, and Ninth Circuits have held that state law claims challenging medically-based eligibility determinations are preempted under *both* § 502 and § 514 of ERISA. Pet. 13-15. Respondent's attempt to recast the holdings of these courts is error.

Contrary to respondent's claim (Opp'n 10-11), the Third Circuit's decision in *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), did not apply *Pegram* like all other courts merely because the Third Circuit "referenced *Pegram* approvingly." This argument is directly at odds with the decision below, which expressly rejected the Third Circuit's analysis of ERISA preemption as "no longer tenable" after *Pegram*. Pet. App. 32a. In contrast to the Second Circuit—which read *Pegram* as "alter[ing] the framework" of preemption analysis (Pet. App. 30a)—the Third Circuit held that *Pegram* merely "suggest[ed] preferable terminology," and otherwise left in place, for purposes of preemption analysis, the distinction between "quality of care" and "benefit eligibility" decisions. *Pryzbowski*, 245 F.3d at 273.

Respondent's attempt to dismiss the Eighth Circuit from the circuit conflict is also in error. Opp'n 13. The Eighth Circuit

held, prior to *Pegram*, that medical malpractice claims are preempted under ERISA where they challenge the medical judgment of a benefits administrator, because it is the plan participant and the participant's doctor that "retai[n] the ultimate decision-making authority regarding . . . medical care." *Thompson v. Gencare Health Sys., Inc.*, 202 F.3d 1072, 1074 (8th Cir. 2000). In *Howard v. Coventry Health Care of Iowa, Inc.*, 293 F.3d 442, 445 (8th Cir. 2002), the court held that *Pegram* did not alter preemption analysis or place eligibility decisions involving medical judgment "outside the scope of ERISA." Thus, even though *Howard* did not, itself, concern a medical judgment (Opp'n 13), it reaffirms earlier precedent that conflicts with the rule of other courts.

Also contrary to respondent's opposition (Opp'n 13), the Sixth Circuit's decision in *Caffey v. UNUM Life Ins. Co.*, 302 F.3d 576 (6th Cir. 2002), conflicts with the decision below. *Caffey* holds that medically-based eligibility determinations are preempted under ERISA. That judgment creates a conflict in legal rule and outcome, whether the opinion expressly discusses *Pegram* or not. For the same reason, the Ninth Circuit's decision in *Elliot v. Fortis Benefits Insurance Co.*, 337 F.3d 1138 (9th Cir. 2003), adds to the conflict. This case, which was decided after the petition in this case was filed, holds that a state law claim challenging a medically-based eligibility determination is "clearly" preempted under § 502 of ERISA. *Id.* at 1147. The decision below is irreconcilable with this holding.

The confusion does not end there, as the Maryland Court of Appeals has adopted an entirely different approach to state law claims challenging medically-based eligibility determinations. That court has held that whether a state law claim challenging a medically-based eligibility determination is preempted by ERISA "is inextricably bound up with the availability of a traditional medical malpractice claim under state law." *Eid v. Duke*, 816 A.2d 844, 852 (Md. 2003). No other court has held that ERISA preemption may vary from

State to State depending on the contours of the State's malpractice law. Respondent attempts to lump the Maryland court's decision together with those of other courts finding no ERISA preemption (Opp'n 9), but in doing so, wrongly ignores the crucial analytical differences between the Maryland court's decision and the decisions of those other courts.

Respondent's suggestion that no confusion exists also ignores that the United States has rejected the Second Circuit's characterization of *Pegram*. Contrary to the court below (Pet. App. 34a), the United States has argued that *Pegram* "addresses only mixed decisions made by treating physicians" and that state law challenges to benefits decisions should be preempted "even if the subject of the decision is 'medical necessity' and the decision-maker is a physician." *Rush Prudential HMO, Inc. v. Moran*, No. 00-1021, 2001 WL 1480556, at *8-*9 (filed Nov. 7, 2001). The United States' position ensures that the controversy in the lower courts will continue.

Finally, respondent errs in suggesting (Opp'n 10-13, 14-15) that the Court should abstain from deciding the question presented until either more courts have addressed the issue or Congress intervenes. As shown in the petition (Pet. 18-22), and the briefs of numerous *amici* (Reply App. 1a-13a), any delay in resolving the split of authority comes at an unacceptably high cost, as "the decision below creates real and immediate operational issues for multistate employee benefit plans that will ultimately harm plan participants." Br. of *amici* AAHP 14. Moreover, according to numerous state attorneys general, delay in resolving the issue hinders "the States' fundamental power to regulate health care." Reply App. 10a-11a. And abstaining in the hope that Congress might intervene is unrealistic and non-responsive. Any legislation on this subject is entirely speculative; and retroactive legislation that would resolve this split in authority

for thousands of pending matters would be contrary to the American legislative tradition.

In sum, contrary to respondent's claims, there is substantial confusion over the important federal question presented. And, as health plans, plan participants, businesses, and States alike have urged, this Court's immediate resolution of the question is necessary.

II. THIS PETITION PRESENTS THE BEST VEHICLE FOR CLARIFYING WHETHER AND HOW ERISA PREEMPTS STATE LAW CLAIMS CHALLENGING MEDICALLY-BASED ELIGIBILITY DETERMINATIONS.

The real issue, therefore, is which of four currently pending petitions should be used to clarify whether and how ERISA preempts state law claims challenging medically-based eligibility determinations. For several reasons, the Court may prefer to use this petition.

The pending *Conover* petition (No. 02-1864) is plainly an unsuitable vehicle. The petition barely discusses the preemption issue raised here, and the case itself primarily concerns whether bad faith claims are excepted from preemption under ERISA's insurance savings clause, § 514(b)(2)(A). *Conover* Opp'n 14-17. There is, however, no conflict among the lower courts on this issue. *Id.* 17-18.

As among the *Calad* (No. 03-83), *Davila* (No. 02-1845), and *Cicio* petitions, all three are worthy of review under this Court's standards for granting *certiorari*. But, the Court may prefer to review this petition.

The decision below clearly elucidates the issues for review, particularly insofar as this Court's decision in *Pegram* is responsible for the lower court confusion. The Second Circuit's decision openly acknowledges the split that has arisen in *Pegram*'s wake, and both the majority and dissenting opinions analyze *Pegram* in depth. *See* Pet. App. 24a-35a; *id.*

37a-43a (Calabresi, J., dissenting). The Fifth Circuit's *Roark* decision, from which the *Calad* and *Davila* petitions arise, does not. As one respected commentator (who also happens to be counsel of record for the *Calad* petitioner) has observed, "*Pegram* was somewhat relegated to being mood music in *Roark*, [but] the same cannot be said for *Cicio* . . . , which squarely held that *Pegram* had changed the complete preemption analysis." R. Eccles & D. Gordon, 11 ERISA Litig. Rptr. 14, 17 (Apr. 2003). That commentator correctly goes on to note that "*Cicio* contains the meatiest discussion of these [preemption] issues . . . ." *Id.* at 23.

In addition, through this petition the Court can fully resolve the preemption question dividing the lower courts. As noted above and in the petition, the lower courts have split into four different camps on the preemption issue, because they disagree *both* about whether state law claims challenging medically-based eligibility determinations are preempted and, if so, about the source and scope of that preemption. Pet. 10-18. As respondent acknowledges (Opp'n 3-4), the court below held that neither § 502 nor § 514 of ERISA preempts such state law claims—and this petition challenges both conclusions. In contrast, the Fifth Circuit *Roark* decision held that only § 514, and not § 502, preempts such claims; and the *Davila* and *Calad* petitions present only the § 502 issue. Thus, only this petition allows the Court to consider both of the issues creating the judicial confusion.

The *Davila* petitioner suggests (*Davila* Reply 9-10) that the § 502 issue must be resolved first anyway. But that is correct, if at all, only in the context of a federal-question removal petition, and not in the context of determining substantive preemption questions, as this Court's own decisions illustrate. *See, e.g.*, *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138-42 (1990) (deciding § 514 preemption issue before § 502 issue in state court action); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-52 (1987) (deciding § 514 preemption before § 502 preemption in diversity action). Moreover, if the Court

were to conclude that § 502 does not completely preempt these state law claims, the Court would still need to decide whether § 514 of ERISA substantively preempts such claims, at least if it is fully to resolve the extant judicial confusion, as § 514 and § 502 have different scopes. *See generally Ingersoll-Rand*, 498 U.S. at 138-45 (separately considering preemption under § 514 and § 502). Only this petition would give the Court that opportunity.

The *Davila* petitioner attempts to sidestep this problem by suggesting (*Davila* Reply 9 n.4) that the Court could address "the Section 514 defense" after resolving the § 502 issue. But the *Calad* and *Davila* petitioners do not raise the § 514 issue in either the questions presented in or the bodies of their respective petitions for *certiorari*. Thus, under the Court's rules and practice, the Court would not address that issue. *See* Sup. Ct. R. 14.1(a); Stern & Gressman, *supra*, at 419-21.

Some arguments have been raised about why this petition may not be the preferred vehicle for resolving the split of authority. But those arguments are misplaced.

First, it makes no difference whether the underlying state law cause of action is based on a "statutory right of action" or state common law. Reply App. 6a n.2. This Court has repeatedly held that ERISA preemption rules apply equally to common law and statutory claims. *See, e.g., Ingersoll-Rand*, 498 U.S. at 139; *Pilot Life*, 481 U.S. at 48.

Second, it also makes no difference that the coverage decision at issue here concerns the "experimental" nature of a treatment rather than its "medical necessity." *Davila* Reply 10. As commentators have noted, either coverage issue is a "typical case in this area," Eccles, *supra*, at 22, and the benefit plan at issue here in fact includes both provisions. Pet. App. 78a. In any event, the distinction between "medical necessity" and "experimental" coverage determinations is irrelevant, because both kinds of determinations may involve medical judgment, and it is the presence of alleged medical

judgment—not the type of medical judgment—that drives the circuit conflict at issue.

Finally, it makes no difference that the court below remanded for the district court to decide "whether the complaint states a cause of action under the law of New York" and whether "*as a matter of fact*, . . . dismissal of the complaint is warranted." Pet. App. at 36a, 37a (emphasis in original). The critical point is that the court held that ERISA does not prevent a State from making actionable alleged medically-based eligibility determinations; and an additional important point is that this ruling of federal law conflicts with the judgments of other courts (and the Executive Branch) and has severe operational implications for employee benefit plans. That petitioners have *other* defenses available to them on remand does not change the importance of this threshold federal question or the utility of this case for deciding that question. Indeed, ERISA preemption questions are issues of law that, as here (and as in *Calad* and *Davila*), are routinely considered on motions to dismiss—even though additional legal and factual defenses can later be interposed. As this Court has recognized, early resolution of this preemption question is necessary to avoid burdening employee benefit plans with inappropriate litigation. *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 363-64 (2002); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 94-95 (1983).

CONCLUSION

The petition for a writ of *certiorari* should be granted.

Respectfully submitted,

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September 2003

No. 02-1826

IN THE
SUPREME COURT OF THE UNITED STATES

ROBERT ROARK, INDIVIDUALLY AND ON BEHALF OF THE ESTATE OF HIS DECEASED WIFE, GWEN ROARK,
Petitioner,

v.

HUMANA INC., HUMANA HEALTH PLAN OF TEXAS, INC. (D/B/A HUMANA HEALTH PLAN OF TEXAS (DALLAS), HUMANA HEALTH PLAN OF TEXAS (SAN ANTONIO), AND HUMANA HEALTH PLAN OF TEXAS (CORPUS CHRISTI)), AND HUMANA HMO TEXAS, INC.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals For the Fifth Circuit

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BRIEF *AMICUS CURIAE* OF AARP IN SUPPORT OF PETITIONER

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REASONS FOR GRANTING THE WRIT

* * *

Supreme Court Rule 10 provides that a "petition for a writ of certiorari will be granted only for compelling reasons." The petitioner's brief has already described the conflict between the Fifth Circuit's decisions in *Corcoran v. United Healthcare*, 965 F.2d 1321 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992), and this case which follows *Corcoran*, and the Second Circuit's decision in *Cicio v. Does*, 321 F.3d 83, 100 (2d Cir. 2003), *petition for cert. filed sub nom. Vytra Healthcare v. Cicio*, [03-69] (U.S. July 11, 2003) which distinguishes *Corcoran* as having been "decided before the Supreme Court's recent retrenchment of ERISA preemption's margins, and before the Court . . . in *Pegram* . . . addressed . . . medical malpractice actions against those engaged in medical decision making." So this brief will not belabor that point. Instead, AARP urges the Court grant the petition because it can settle an important question of federal law which determines the legal accountability for the millions of health care treatment decisions routinely made by MCOs.

* * *

The Court has the opportunity to bring certainty to this issue that plagues so many lower courts.[11] While AARP obviously believes that ERISA should not be interpreted to make managed care entities immune from liability where they have caused grievous injury by negligently denying care, no matter the Court's final conclusion, AARP believes it is

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[11] *See, e.g., Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001); *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003 (9th Cir. 1998); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001).

incumbent upon the Court to sort out federal jurisprudence in such a way to bring consistency to the interpretation of federal law. The development of the law has reached the point that a definitive answer is needed.

CONCLUSION

For the above reasons, AARP urges the Court to grant the petition for a writ of certiorari.

No. 02-1826

IN THE
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ROBERT ROARK, Individually and on Behalf of the Estate of GWEN ROARK, Deceased,

Petitioner,

v.

HUMANA, INC.; HUMANA HEALTH PLAN OF TEXAS, INC., d/b/a HUMANA HEALTH PLAN OF TEXAS (DALLAS), HUMANA HEALTH PLAN OF TEXAS (SAN ANTONIO), HUMANA HEALTH PLAN OF TEXAS (CORPUS CHRISTI), and HUMANA HMO TEXAS, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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REASONS WHY THE PETITION SHOULD BE GRANTED

The Fifth Circuit's decision conflicts with this Court's recent opinions narrowing the breadth of ERISA preemption and squarely contradicts a recent decision by the United States Court of Appeals for the Second Circuit on the same important matter.[2] Numerous other federal circuits have divided on this issue, both actually and in principle, and decisions from a number of state courts conflict as well. Laws similar to the Texas statute at issue here have been passed in nine other states. Several more state courts of last resort permit such claims as a matter of common law. As a result, this issue will continue to arise throughout the country, absent guidance from this Court. Finally, the United States has advocated to this Court previously that this is an issue of national importance which should be addressed.

This issue affects the health care coverage of tens of millions of Americans. The conflict in the lower courts creates uncertainty, inconsistency and inefficiency in the judicial branches of the state and federal governments. These are reasons enough to grant Mr. Roark's petition.

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[2] That case, *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003), has also prompted a petition for writ of certiorari, which was filed on July 11, 2003. That petition highlights the importance of the question presented by Mr. Roark. *Amici* believe that this case is a more appropriate vehicle for addressing the issues presented in these petitions in part because the Texas legislature has clearly created a statutory right of action. Petitions have also been filed in *Roark*'s companion cases in the Fifth Circuit, *Cigna Healthcare of Texas v. Calad*, No. 03-83, and *Aetna Health Inc. v. Davila*, No. 02-1845, which also construe the Texas statute at issue here but which were decided solely on ERISA § 502(a)(1)(B) "complete preemption" grounds.

* * *

CONCLUSION

For all the foregoing reasons, the petition should be granted.

No. 02-1826

IN THE
SUPREME COURT OF THE UNITED STATES

ROBERT ROARK, INDIVIDUALLY AND ON BEHALF OF THE ESTATE OF HIS DECEASED WIFE, GWEN ROARK,
Petitioner,

v.

HUMANA INC., HUMANA HEALTH PLAN OF TEXAS, INC. (D/B/A HUMANA HEALTH PLAN OF TEXAS (DALLAS), HUMANA HEALTH PLAN OF TEXAS (SAN ANTONIO), AND HUMANA HEALTH PLAN OF TEXAS (CORPUS CHRISTI)), AND HUMANA HMO TEXAS, INC.,
Respondents.

On Petition for a Writ of Certiorari to the
United States Court of Appeals for the Fifth Circuit

BRIEF OF THE STATES OF TEXAS, ALABAMA, CALIFORNIA, DELAWARE, HAWAII, MINNESOTA, MISSOURI, NEVADA, OKLAHOMA, OREGON, UTAH, WASHINGTON, D.C., WEST VIRGINIA, WISCONSIN, WYOMING AND THE COMMONWEALTH OF PUERTO RICO AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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* * *

SUMMARY OF THE ARGUMENT

Traditionally, States have been the primary protectors of the public health and welfare. The Court has, on many occasions, noted the historic state function of regulating health care. Moreover, since it issued *Travelers* in 1995, it has expressly recognized that Congress did not intend to supplant state law regarding health care in enacting ERISA.

Nonetheless, because it perceived itself to be bound by prior circuit precedent, the panel below followed the Fifth Circuit's earlier decision in *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (CA5 1992), to hold that a claim under a Texas statute requiring that HMO health care decisions regarding medical necessity be executed using ordinary care was preempted by ERISA. The panel's decision is in direct conflict with the Second Circuit's decision in *Cicio v. Does*, 321 F.3d 83 (CA2 2003), construing a similar New York law.

* * *

The Court should grant the petition for writ of certiorari to resolve the conflict between the circuits and to clarify the bounds of ERISA preemption in this area of traditional state regulation.

* * *

The Second Circuit, the Pennsylvania and Florida Supreme Courts, and the Ninth Circuit in a related FEHBA case have all reached the correct result. State efforts to regulate the provision of health care by requiring HMO medical-necessity decisions to be executed using ordinary care, and the creation of a malpractice claim to redress injury caused by a failure to abide by that standard, should not be swept into—and thus invalidated by—ERISA preemption. The Fifth Circuit's opinion at issue here conflicts with those decisions and is out of step with this Court's evolving ERISA jurisprudence

respecting the States' fundamental power to regulate health care.

CONCLUSION

The Court should grant the petition for writ of certiorari.

IN THE
SUPREME COURT OF THE UNITED STATES

No. 02-1845

AETNA HEALTH, INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

On Petition for a Writ of Certiorari To The United States Court of Appeals For the Fifth Circuit

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BRIEF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS, INC., THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA, THE AMERICAN BENEFITS COUNCIL AND THE NATIONAL ASSOCIATION OF MANUFACTURERS AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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* * *

REASONS FOR GRANTING THE PETITION

* * *

This Court should grant the petition to make clear what seems obvious—the *Pegram* Court was analyzing a treating physician making a *direct treatment decision* with respect to a patient. The Court was not analyzing the action of an ERISA fiduciary acting in an administrative capacity. And the *Pegram* Court had "no occasion" to address the scope of preemption under ERISA sections 514 and 502 with respect to such claims decisions even when such decisions are alleged to involve some medical judgment. *Id.* at 229, n.9. But *Davila* reflects the Fifth Circuit's judgment that *Pegram* overrules *Pilot Life* and *Taylor*. Instead, the Fifth Circuit should have followed the settled principle that the Court does "not normally overturn, or so dramatically limit, earlier authority *sub silentio*." *See Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 3 (2000).

* * *

CONCLUSION

The petition for writ of certiorari should be granted.

(5)

Supreme Court, U.S.
FILED
OCT 16 2003
CLERK

No. 03-69

IN THE

Supreme Court of the United States

VYTRA HEALTHCARE AND BRENT SPEARS, M.D.,
Petitioners,

v.

BONNIE CICIO
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

SUPPLEMENTAL BRIEF OF PETITIONERS

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SUPPLEMENTAL BRIEF

Pursuant to Supreme Court Rule 15(8), Petitioners submit this supplemental brief to call to the Court's attention a decision issued after Petitioners' last filing that is relevant to this petition. *See DiFelice v. Aetna U.S. Healthcare*, No. 02-3381 (3d Cir. Oct. 15, 2003) (attached as an appendix to this brief).

In *DiFelice*, the Third Circuit considered the question presented by this petition and held that the Employee Retirement Security Act of 1974 ("ERISA") completely preempts state law claims that challenge a non-treating physician's alleged medical judgment in determining eligibility for coverage under an employee benefit plan, specifically the non-treating physician's judgment of medical necessity. *See* Supplemental App. at 10-17. In doing so, the Third Circuit rejected the argument that this Court's decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000), has altered preemption analysis and expressly recognized the conflict among the courts of appeals on this ERISA preemption question. *See id.* at 14-15 n.3. Accordingly, the decision further confirms the need for this Court's immediate intervention.

CONCLUSION

The petition for a writ of *certiorari* should be granted.

Respectfully submitted,

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October 2003

APPENDIX

PRECEDENTIAL
Filed October 15, 2003

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 02-3381

JOSEPH V. DIFELICE, JR.,
Appellant

v.

AETNA U.S. HEALTHCARE; MICHAEL PICARIELLO, M.D.; SARAH FOWLER; EAR NOSE & THROAT ASSOC. OF CHESTER COUNTY, INC.; CHESTER COUNTY HOSPITAL

Appeal from the United States District Court
for the Eastern District of Pennsylvania
(D.C. Civil No. 02-cv-03641)
District Judge: Honorable John P. Fullam

Argued March 14, 2003
(Filed October 15, 2003)

Before: BECKER, *Chief Judge*,* RENDELL and AMBRO, *Circuit Judges*.

* Judge Becker completed his term as Chief Judge on May 4, 2003.

OPINION OF THE COURT

RENDELL, *Circuit Judge.*

We are once again called upon to determine whether a lawsuit claiming medical negligence is completely preempted by the civil enforcement provision of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a). Joseph V. DiFelice, Jr., appeals the order of the United States District Court for the Eastern District of Pennsylvania dismissing his complaint against Aetna/U.S. Healthcare, Inc. ("Aetna") for negligent conduct in regard to his medical treatment for sleep apnea and upper airway obstruction. DiFelice filed suit in state court, alleging that Aetna's instruction to his treating physician that a specially designed tracheostomy tube was "medically unnecessary" and Aetna's insistence that he be discharged from the hospital before his attending physician deemed it appropriate amounted to negligent conduct under state law. Aetna removed the case to federal court on the basis of ERISA preemption and then moved to dismiss the claim. The District Court, relying on our decision in *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), held that the claim was completely preempted and dismissed it in its entirety. For the reasons that follow, we will affirm in part and reverse in part.

I.

DiFelice participates in an ERISA-governed employee welfare benefit plan that is administered by Aetna, a health maintenance organization ("HMO"). Under the terms of this plan, DiFelice is entitled to certain "Covered Benefits." Unless there is a specific provision for a particular type of treatment, a benefit is only covered if, in the determination of Aetna, it is "Medically Necessary." "Medically Necessary" is a defined term, meaning the service or supply must be "care or treatment as likely to produce a significant

positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply;" must be "related to diagnosis of an existing illness or injury;" may "include only those services and supplies that cannot be safely and satisfactorily provided at home;" and, "as to diagnosis, care and treatment[, must] be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply."

In March 2001, DiFelice was diagnosed with "sleep apnea/upper airway obstruction," for which he required a tracheostomy tube.[1] His doctor, Dr. Michael Picariello, surgically inserted a tracheostomy tube to eliminate the obstruction, but that tube continually came out. Dr. Picariello then placed an order for a specially designed tube. However, Aetna instructed Dr. Picariello that the special tube was "medically unnecessary." Instead of ordering the special tube, the doctor then inserted a different tube, which caused DiFelice severe pain and resulted in an infection. DiFelice was later admitted to Chester County Hospital for treatment, but, the complaint avers, was thereafter discharged "at Aetna's insistence."[2]

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[1] Our recitation of the facts is derived from DiFelice's complaint.

[2] DiFelice objects to our consideration of the terms of the Plan in determining whether his complaint should be dismissed because he does not reference the Plan in his complaint, and Aetna did not argue below that the Plan provisions were dispositive. However, in ruling on a motion to dismiss, we may consider an extrinsic document that is "integral" to the complaint. *See In re Burlington Coat Factory Sec. Litig.*, 114 F.3d 1410, 1426 (3d Cir. 1997). Here, DiFelice's reference to "medical necessity" is clearly derived from the terms of the Plan. Furthermore, even if Aetna did not explicitly argue that the Plan provisions controlled the decision in this case, Aetna attached the Plan as an exhibit to its brief and motion before the District Court. DiFelice was certainly on notice that the Plan terms were integral to Aetna's argument.

DiFelice filed a five-count complaint in the Philadelphia Court of Common Pleas against Aetna, his treating physicians, and the hospital. In Count I, he alleged that Aetna negligently interfered with his medical care "by instructing Dr. Picariello that the specially designed tracheostomy tube he deemed necessary was medically unnecessary for [DiFelice] and improperly interfering with Dr. Picariello's medical decision concerning the tracheostomy tube and insisting on [DiFelice's] discharge from the [hospital] . . . before his attending physician was planning on discharging [him]." The other counts involved claims against parties other than Aetna. Aetna removed the case to the District Court on the grounds that the claim against it was completely preempted under ERISA and then moved to dismiss. DiFelice opposed the motion to dismiss and moved to remand to state court.

The District Court denied DiFelice's motion to remand and granted Aetna's motion to dismiss as to Count I, and granted the motion to remand on the remaining counts against the other parties. The Court held that the disposition of Count I was "squarely controlled by the Third Circuit's decision in *Pryzbowski*," in which we held that a claim challenging the "administration of or eligibility for benefits" was completely preempted by section 502(a)(1)(B) of ERISA. *Pryzbowski*, 245 F.3d at 273. The Court reasoned that the claim against Aetna was completely preempted because DiFelice was challenging Aetna's decision that he was not entitled to the special tube under the Plan, which was entirely a matter of administration, and because Aetna was not actually involved in providing any medical services to DiFelice. DiFelice appeals the District Court's order dismissing Count I.

II.

We have jurisdiction over the District Court's final order pursuant to 28 U.S.C. § 1291, and review the Court's exercise of jurisdiction and order of dismissal de novo.

Pryzbowski, 245 F.3d at 268. Aetna bears the burden of proving the federal jurisdiction it seeks. *Spectacor Mgt. Group v. Brown*, 131 F.3d 120, 127 (3d Cir. 1997). In reviewing the complaint, we must accept as true all of DiFelice's factual allegations and draw all reasonable inferences therefrom. *Langford v. City of Atlantic City*, 235 F.3d 845, 847 (3d Cir. 2000).

DiFelice challenges the District Court's removal jurisdiction over Count I of his complaint and asks us to remand to state court. He argues that his negligence action against Aetna is entirely a matter of state law and provides no basis for removal. Aetna counters that DiFelice's negligence action is in fact nothing more than an action to recover benefits due under his plan, and as such is completely preempted by the civil enforcement provision of ERISA, section 502(a).

A. Framework

Under the "well-pleaded complaint" rule, federal question jurisdiction only exists where an issue of federal law appears on the face of the complaint. *Franchise Tax Bd. Of Cal. v. Constr. Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 24 (1983). However, there is an exception to this rule: when a purportedly state-law claim "comes within the scope of [an exclusively] federal cause of action," it "necessarily 'arises under' federal law," and is completely preempted. *Id.*; *see also Beneficial Nat'l Bank v. Anderson*, 123 S. Ct. 2058, 2062 (2003) (explaining the preemptive effect of ERISA). The question before us is therefore whether DiFelice's claims of state law negligence on the part of Aetna fall within the scope of the federal causes of action provided in section 502(a) of ERISA, that is, whether the claims could have been brought under that section. If so, then the existence of the federal claim would provide the basis for federal question jurisdiction but at the same time would require dismissal based on complete preemption.

We have had numerous occasions to consider the question of whether a plaintiff 's claim against an HMO is covered by section 502(a) and is therefore completely preempted. *See, e.g., Pryzbowski*, 245 F.3d at 273-75; *Lazorko v. Pa. Hosp.*, 237 F.3d 242, 250 (3d Cir. 2000); *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 162-63 (3d Cir. 1999); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 358 (3d Cir. 1995). Determining whether a claim could have been brought under ERISA has proven to be anything but an exact science. In fact, as my colleagues' concurring opinions point out all too well, the exercise seems to have taken on a life of its own, and not a very satisfying or productive life at that. In any event, the statute and our case law chart the path we must follow.

Section 502(a) allows for civil actions to be brought "by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). The line between an action to recover benefits, which challenges an administrative decision regarding whether a certain benefit is covered under an ERISA plan, and an action alleging negligence or malpractice, which challenges the medical treatment actually provided to a patient, is a blurry one. We have been continually refining the precise test we use in evaluating such claims.

Most recently, in *Pryzbowski*, we synthesized the discussions contained in our previous opinions and adopted preferable new terminology. We explained that in the past we had attempted to distinguish between claims directed at the *quality* of benefits received–that is, as to the treatment–which would not fall within section 502(a), and claims that the plans erroneously withheld a *quantum* of benefits due–focusing on the administration of the plan–which would be completely preempted. *Pryzbowski*, 245 F.3d at 272. Following this "quality-quantity" rubric, we had held that an allegation that an HMO had failed to exercise reasonable care in providing medical treatment was not

preempted, *Dukes*, 57 F.3d at 358; an allegation that an HMO's policy of discharging newborns within 24 hours after their delivery was essentially a medical determination and was not preempted, *In re U.S. Healthcare*, 193 F.3d at 163; and an allegation that an HMO's financial disincentives discouraged medical providers from hospitalizing a mentally ill woman was a "quality of care" claim because it occurred in the course of a treatment decision, and was therefore not preempted. *Lazorko*, 237 F.3d at 250.

However, in *Pryzbowski*, we found the "quality-quantity" distinction unclear, and suggested that more helpful terminology was utilized by the Supreme Court in *Pegram v. Herdrich*, 530 U.S. 211 (2000). Although we recognized that *Pegram* "concerned fiduciary acts under ERISA and not preemption," we found useful "the distinction made there between *eligibility decisions*, which turn on the plan's coverage of a particular condition or medical procedure for its treatment," and "*treatment decisions*, which are choices in diagnosing and treating a patient's condition," and determined that the distinction was "equally applicable for complete preemption analysis." *Pryzbowski*, 245 F.3d at 273 (quoting *Pegram*, 530 U.S. at 228) (emphasis added and internal quotations omitted). We then explained,

> Regardless of the language used, the ultimate distinction to make for purposes of complete preemption is whether the claim challenges the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted, or the quality of the medical treatment performed, which may be the subject of a state action.

Id.

Using this nomenclature, it was evident to us in *Pryzbowski* that "a claim alleging that a physician knowingly delayed in performing urgent surgery . . . would relate to the quality of care," while on the other hand, "a claim alleging

that an HMO declined to approve certain requested medical services or treatment on the ground that they were not covered under the plan would manifestly be one regarding the proper administration of benefits." *Id.* (citing *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1488-89 (7th Cir. 1996)). However, we were presented there with claims that fell somewhere in between: that an HMO had negligently delayed approval of an out-of-network specialist, and that it had failed to supervise properly its employees to make "thoughtful and reasonable decisions as to healthcare." *Id.* at 274. Were those claims based on a treatment decision or on a determination as to eligibility for a benefit? We explained that "[i]n analyzing whether a claim falling between the[ ] two poles is completely preempted, it is necessary to refer to § 502(a)." *Id.* at 273. Paring the issue down to its essence, we stated that the relevant question must be whether the claim "could have been the subject of a civil enforcement action under § 502(a)." *Id.* If it could have, then it was a plan benefit claim, and Congress has clearly expressed its intent that the claim be preempted by ERISA. *Id.* (citing *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987)).

Because the claims in *Pryzbowski* fell between the two poles, we took extra care to examine the complaint for "artful pleading," to ensure that Pryzbowski was not disguising an eligibility claim that could have been brought under ERISA as a state law negligence claim. We explained that, although the claim might be "ostensibly directed at the provision of medical treatment," we needed to "look beyond the face of the complaint to determine whether [Pryzbowski had] artfully pleaded his suit so as to couch a federal claim in terms of state law." *Id.* at 274 (quoting *Jass*, 88 F.3d at 1488); *see also Franchise Tax Bd.*, 463 U.S. at 22 ("[A] plaintiff may not defeat removal [to federal court] by omitting to plead necessary federal questions in a complaint."). The ultimate question was whether, when the

basis for the claim was properly understood, the claim fell under ERISA.

After carefully examining Pryzbowski's complaint for the true bases of his claims, we held that his claims were completely preempted. First, regarding the delayed approval, we concluded that underlying the HMO's allegedly negligent activities was a *policy* decision regarding payment to and approval of out-of-network specialists, a decision that fell "within the realm of the administration of benefits." *Pryzbowski*, 245 F.3d at 273. We explained that this claim could have been brought under ERISA because "[h]ad Pryzbowski sought to accelerate [the HMO]'s approval of the use of out-of-network providers, she could have sought an injunction under § 502(a) to enforce the benefits to which she was entitled under the plan." *Id.* at 273-74. Further, her claim that the HMO had "failed to properly hire, train, and supervise its employees to make thoughtful and reasonable decisions as to healthcare" was also preempted because, reading behind the artful "medical negligence" pleading, the complaint did not allege that the HMO or its employees had actually engaged in any medical treatment. *Id.* at 274. Because the HMO's only role was in administering Pryzbowski's benefits, it could not possibly have been negligent in providing treatment. *Id.* Unlike the situation in which an HMO fills dual roles as an administrator of benefits *and* a provider of services, and might therefore actually engage in medical treatment, the HMO there was acting *solely* as an administrator. *Id.*

Pryzbowski thus instructs us to determine whether a claim is preempted under section 502(a) by first examining whether the claim falls at either of the two poles, entirely treatment or entirely administrative. If based solely on a medical treatment decision, then the claim is not preempted. If based on an HMO administrator's eligibility decision, then the claim is preempted. In the more difficult situation in which the claim falls somewhere in between, we must

scrutinize the complaint for "artful pleading," and then refer to section 502(a) itself and determine whether the actual alleged wrongdoing underlying the cause of action could have formed the basis of a suit under that section.

As discussed more fully below, when we apply the *Pryzbowski* framework to the complaint before us, we conclude that DiFelice's claim that Aetna "interfered with" his medical treatment by declaring the special tube "medically unnecessary" is preempted by ERISA because it could have been brought as an action under section 502(a). However, because it appears that DiFelice's claim that he was discharged "at the insistence of Aetna" does not rest on any discharge policy set forth in the Plan, or any agreed benefit, it would not be encompassed within the relief available under section 502(a) and is therefore not completely preempted.

B. The Tracheostomy Tube

We will first examine DiFelice's claim that Aetna interfered with Dr. Picariello's medical decision regarding the special tube. Under *Pryzbowski*, the first question is whether Aetna's "medical necessity" determination is clearly either a medical treatment decision or an eligibility decision. DiFelice has couched this claim in terms of Aetna's negligent interference with his care, which seems to imply that Aetna itself engaged in medical treatment. However, DiFelice's complaint does not include any allegation that Dr. Picariello was an agent of Aetna, that Aetna did not exercise reasonable care in monitoring Dr. Picariello's care, or that Aetna itself provided medical treatment; rather, his claim rests on Aetna's "instruction" to Dr. Picariello "that the specially designed tracheostomy tube he deemed necessary was medically unnecessary," a direct reference to the "medical necessity" determination called for in the Plan. Looking behind DiFelice's use of language sounding in negligence, he is alleging that Aetna wrongfully denied him coverage for the special tube. Thus, the complaint has

aspects of treatment and coverage. That is, in making its determination, Aetna necessarily had to exercise some medical judgment, i.e., it had to determine whether the special tube was "as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, . . . [was] related to diagnosis of an existing illness or injury, . . . [and was] no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply." However, here there is no allegation that Aetna actually provided the medical care, and Aetna's use of medical judgment could only have led to an eligibility, not a treatment, decision.

Because the decision here was in some sense both a medical treatment and an eligibility decision, thus falling between the two poles discussed in *Pryzbowski*, we must refer to section 502(a) and determine whether DiFelice's claim regarding the tube could have been the subject of a civil enforcement action under ERISA. *Pryzbowski*, 245 F.3d at 273. Clearly, it could have been. DiFelice could have challenged Aetna's "medical necessity" determination by filing a claim under 502(a)(1)(B) "to recover benefits due to him under the terms of his plan," and arguing that the special tube was in fact "medically necessary," and was therefore a "covered benefit." He could have requested an injunction forcing Aetna to pay for the special tube, or alternatively, paid for the tube himself and then later filed an action for reimbursement. Numerous ERISA participants have in fact brought such actions challenging their HMO's "medical necessity" determinations and seeking to recover benefits they alleged were due under their plans. *See, e.g.*, *Mario v. P&C Food Mkts., Inc.*, 313 F.3d 758, 762-63 (2d Cir. 2002) (reviewing claim under section 502(a) challenging HMO's determination that sex change operation was not "medically necessary"); *Fritcher v. Health Care Serv. Corp.*, 301 F.3d 811, 814-15 (7th Cir. 2002) (reviewing claim under section 502(a) challenging HMO's determination that custodial care

was not "medically necessary"); *Kopicki v. Fitzgerald Auto. Family Employee Benefits Plan*, 121 F. Supp. 2d 467, 480 (D. Md. 2000) (granting preliminary injunction to prevent HMO from denying preauthorization for cancer treatment it had deemed not "medically necessary"); *see also Heasley v. Belden & Blake Corp.*, 2 F.3d 1249, 1253 (3d Cir. 1993) (reviewing claim under section 502(a) challenging an HMO's determination that a liver/pancreas treatment was an "experimental procedure"). DiFelice's claim falls squarely within this jurisprudence. Because DiFelice's claim that Aetna improperly deemed his special tube to be "medically unnecessary" could have been brought under section 502(a), it is completely preempted by ERISA. We will therefore affirm the District Court's exercise of removal jurisdiction and its order dismissing Count I as to Aetna's conduct regarding the tracheostomy tube.

DiFelice urges that this result is inconsistent with the Supreme Court's decision in *Pegram* and our decisions in *U.S. Healthcare* and *Lazorko*. We disagree.

In *Pegram*, the Supreme Court answered the question whether an HMO may be liable for a breach of fiduciary duty when its physician owners make "mixed eligibility and treatment decisions." *Pegram*, 530 U.S. at 229. There, a physician, who was also an owner of the HMO that covered her patient, waited to order an ultrasound for the patient's inflamed appendix, and the appendix ruptured. *Id.* at 215. The patient sued the HMO for breach of fiduciary duty, alleging that the HMO created an incentive for the physicians to make decisions in their own financial interests, rather than in the exclusive interests of the plan participants. *Id.* The Court held that HMOs do not act as "fiduciaries" as envisioned by ERISA when their physician owners make decisions that touch both on the patient's medical treatment and the patient's eligibility for benefits under the plan. *Id.* at 218.

The Court first set forth a framework for understanding the kinds of acts that physician owners acting on an HMO's behalf might undertake. On the one hand are "pure 'eligibility decisions'" turning on the plan's coverage for a particular medical treatment, and on the other are "treatment decisions," choices about how to go about diagnosing and treating a patient's condition. *Id.* at 228. In between are situations in which the "eligibility decision and the treatment decision [are] inextricably mixed," that is, when an eligibility decision necessarily rests on the "physicians' judgments about reasonable medical treatment." *Id.* The Court found that it was presented with just such a "mixed" decision: the physician owner had determined that the patient's "condition did not warrant immediate action; the consequence of that medical determination was that [the HMO] would not cover immediate care." *Id.*

Having concluded that the decision before it was a "mixed" decision, the Court went on to hold that an HMO's physician owners do not act as fiduciaries under ERISA when making such decisions. *Id.* at 231. The Court focused on the nature of "fiduciaries," explaining that these mixed decisions are not "fiduciary in nature," and bear "only a limited resemblance to the usual business of trustees." *Id.* The Court feared that a contrary result would open the floodgates to malpractice suits against HMOs and individual physicians under the guise of ERISA breach of fiduciary duty claims, and would erode the distinction between state malpractice and federal ERISA actions. *Id.* at 235-36.

Although, as we noted above, *Pegram* set forth helpful terminology for preemption analysis, *see Pryzbowski*, 245 F.3d at 273, the Court's holding that a "mixed" determination made by a physician owner does not subject an HMO to liability for breach of fiduciary duty does not translate to, or govern in, the preemption context. Rather, *Pegram* sets a standard for when liability is to be imposed on individuals acting in a fiduciary capacity. It does not

presume to encompass ERISA claims enforcement as such. In fact, the *Pegram* Court specifically stated that it was *not* discussing the standards governing a claim that a patient had been wrongfully denied benefits due under a plan nor the interaction between such a claim and state law causes of action. *Pegram*, 530 U.S. at 229 n.9; *accord Roark v. Humana, Inc.*, 307 F.3d 298, 308 (5th Cir. 2002) (stating that the Supreme Court has not decided whether section 502(a)(1)(B) preempts a medical malpractice claim involving "mixed decisions," but holding under Fifth Circuit law that it does not). In fact, it could be argued that allowing plaintiffs to do an end-run around ERISA by permitting them to couch *plan decisions* that have some impact on treatment in negligence terms would have a similar effect of undermining ERISA as was feared by the Court in *Pegram*. We remain convinced that, after *Pryzbowski*, we look at what decisions are subject to enforcement, which is a radically different inquiry from when can an HMO be sued for breach of fiduciary duty.[3]

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[3] We note that other federal courts of appeals have followed different paths in determining whether a claim is preempted under section 502(a). Some have concluded, on the facts before them, that a suit challenging a "medical necessity" determination was preempted, *see Marks v. Watters*, 322 F.3d 316, 326-27 (4th Cir. 2003) (holding that a suit against an HMO utilization review case manager was completely preempted under section 502(a) because the HMO did not actually provide medical treatment); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1489 (7th Cir. 1996) (holding that a negligence claim against an HMO utilization review case manager was completely preempted because the claim was "in effect a claim for denial of benefits"), and some have concluded that it was not. *See Land v. CIGNA Healthcare of Fla.*, 339 F.3d 1286, 1293 (11th Cir. 2003) (holding that claims that an HMO failed to correctly diagnose a condition and authorize proper medical treatment were tort claims outside of the scope of section 502(a)); *Cicio v. Does*, 321 F.3d 83, 102 (2d Cir. 2003) (concluding that under *Pegram*, a state law medical malpractice action based on a "mixed" decision is not preempted by ERISA when the state law cause of action "challenges an allegedly

We are also not persuaded that *U.S. Healthcare* and *Lazorko*–both of which pre-date *Pryzbowski* and rely on the "quality-quantity" distinction–compel a different result. In *U.S. Healthcare*, we held that a suit against an HMO challenging its policy of pre-certifying a twenty-four hour discharge of mother and newborn was not preempted by ERISA because it went to the quality of the health care provided. *U.S. Healthcare*, 193 F.3d at 162. Significantly, we noted that the plaintiffs did not allege "a failure to provide or authorize benefits under the plan," nor did they claim "that they were denied any of the benefits that were due under the plan." *Id.* Rather, they alleged that the HMO was negligent in *adopting* the discharge policy and in supervising the physicians with whom they contracted for services, and that the HMO's incentive structure adversely affected the physicians' medical judgment regarding when newborns should be discharged. The plaintiffs were not seeking to enforce benefits they thought were due to them under the plan; they were challenging the discharge policy itself and the HMO's actions "in its role as a provider or arranger of medical services," not in its role as administrator of benefits. *Id.* at 163. The HMO's "policy and incentive structure were such that the [patients] never had the option of making an informed decision as to whether to pay for the hospitalization themselves, as would occur in a situation in which coverage is sought and denied." *Id.* Although we

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flawed medical judgment as applied to a particular patient's symptoms"); *Roark v. Humana, Inc.*, 307 F.3d 298, 309 (5th Cir. 2002) (holding that a claim that an HMO had failed to use ordinary care in making a medical necessity determination sounded in tort and was not preempted). We believe that the framework we set forth in *Pryzbowski* provides the controlling method of analysis here and compels the conclusion that DeFelice's claim regarding the tube is preempted.

analyzed the claims in *U.S. Healthcare* under the "quality-quantity" rubric, our holding squares with the preemption framework we later set forth in *Pryzbowski.* Because the plaintiffs in *U.S. Healthcare* were not suing for any benefits due under the plan, but rather were challenging the plan itself, they could not have sued under section 502(a), and therefore, even under *Pryzbowski*, their claims would not have been preempted.

Lazorko involved a similar issue. There, we held that a claim that financial disincentives imposed by an HMO discouraged medical providers from hospitalizing a patient who later committed suicide was a "quality of care" claim and therefore not preempted. *Lazorko*, 237 F.3d at 249-250. We noted that Lazorko was not claiming that the HMO plan was supposed to include hospitalization, but rather that her doctor was influenced in his decision-making by the incentive structure. *Id.* As in *U.S. Healthcare*, the patient could not have sued under ERISA because she never had the option of seeking continued hospitalization–her doctor, as influenced by the HMO policy, did not offer it to her. *Id.*

Unlike in *U.S. Healthcare* and *Lazorko*, here, DiFelice is suing based on denial of a benefit he claims he was due under the Plan. He is not claiming that Aetna negligently adopted a particular policy regarding tracheostomy tubes or imposed an incentive structure that interfered with his physician's independent medical judgment. Rather, he claims that the special tube was not "medically unnecessary," and that Aetna wrongfully determined that it was, a claim that is based on the language of the Plan and pertains to the nature of benefits provided. Unlike the plaintiffs in *U.S. Healthcare* and *Lazorko*, DiFelice sought and was denied coverage for a benefit, and could have paid for the benefit himself and sued under section 502(a) for reimbursement.

Because under our most recent controlling precedent, *Pryzbowski*, DiFelice's claim that Aetna was negligent in

determining that the special tube was "medically unnecessary" could have been the subject of a suit under section 502(a) for benefits due under the Plan, his claim is preempted by ERISA.[4] We will therefore affirm the District Court's exercise of removal jurisdiction and subsequent dismissal of the claim with respect to the tube.

C. The Discharge from the Hospital

Count I also includes a claim that Aetna improperly interfered with DiFelice's medical treatment by "insisting on [his] discharge from the [hospital] . . . before his attending physician was planning on discharging [him]." The District Court did not address this aspect of the claim in its order dismissing the complaint.

Unlike his claim regarding the tracheostomy tube, DiFelice does not allege that Aetna deemed the hospital stay to be "medically unnecessary" and therefore not covered by the Plan. The claim also does not appear to rely on a discharge policy in the Plan or any agreed benefit. Indeed, it is difficult to tell from DiFelice's vague pleadings what

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[4] Aetna argues that the Supreme Court's decision in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), compels this result, but we find that case to be inapposite. The Court in *Moran* was faced with an Illinois statute that provided HMO participants "with a right to independent medical review of certain denials of benefits," *id.* at 359, and required HMOs to provide any service that the independent reviewing physician deemed "medically necessary." *Id.* at 361. The Court held that "it was beyond serious dispute" that the statute "related to" an ERISA plan and was therefore preempted under 29 U.S.C. § 1144(a), but went on to hold that the statute was saved from preemption under 29 U.S.C. § 1144(b)(2)(A) because it regulated insurance. *Id.* at 365-66. Thus, the Court was not faced with the question of whether a suit challenging an HMO's medical necessity determinations would be preempted under ERISA absent a particular state statute that imposed additional burdens on the HMO, which is the issue before us here.

precisely he is alleging that Aetna did or the form this "insistence" took. If Aetna in some way forced the hospital to discharge him, or imposed financial incentives like those in *U.S. Healthcare* and *Lazorko* that unduly affected his physician's judgment, then DiFelice has pled a negligence cause of action that is not preempted by ERISA.

At the dismissal stage, it was Aetna's burden to prove federal jurisdiction by proving that this is an ERISA claim. *See Spectacor Mgt. Group*, 131 F.3d at 127. There is nothing apparent from the pleadings that would foreclose DiFelice from being able to prove that the discharge decision was not a plan benefit. Unlike his claim that the tube was erroneously determined to be "medically unnecessary" under the Plan, this claim on its face is not plan-related. Therefore, because DiFelice's claim of "insistence" on the discharge could give rise to state law negligence liability, we hold that it is not completely preempted by section 502(a) of ERISA.

Aetna argues that, even if DiFelice's hospital discharge claim is cognizable as a state law cause of action, we should uphold the District Court's dismissal of that claim on the alternative ground that it is nonetheless expressly preempted by virtue of section 514 of ERISA, 29 U.S.C. § 1144(a), which provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the statute. However, "[u]nlike the scope of § 502(a)(1)(B), which is jurisdictional and creates a basis for removal to federal court, § 514(a) merely governs the law that will apply to state law claims, regardless of whether the case is brought in state or federal court." *Lazorko*, 237 F.3d at 248. As we have determined that the hospital discharge claim is not preempted by section 502(a), we do not have jurisdiction over that claim. Rather, the question of whether the hospital discharge claim will be controlled by federal law pursuant to section 514 must be decided by the District Court on remand, should it choose to exercise supplemental jurisdiction under 28 U.S.C.

§ 1367(a), or by the state court. *See Pryzbowski*, 245 F.3d at 276 (where District Court has jurisdiction over one claim by virtue of preemption under section 502(a), it has discretion to decide whether to exercise supplemental jurisdiction over claims arising from the same factual predicate or remand to state court).

III.

Because DiFelice's claim that Aetna interfered with his medical treatment by finding the special tracheostomy tube to be "medically unnecessary" could have been brought under section 502(a) of ERISA for the recovery of benefits due under his plan, it is completely preempted. We will therefore affirm the order of the District Court dismissing that claim. However, because Aetna has not shown that DiFelice's claim that Aetna interfered with his medical treatment by insisting on his discharge from the hospital is based on any plan benefit, that claim is not completely preempted. We will therefore reverse the District Court's order dismissing that claim and remand for further proceedings.

BECKER, *Circuit Judge*, concurring.

I am satisfied that Judge Rendell's opinion reaches the correct result under our governing caselaw. While I thus join in her opinion and in the judgment, I write separately to add my voice to the rising judicial chorus urging that Congress and the Supreme Court revisit what is an unjust and increasingly tangled ERISA regime.

Congress enacted ERISA in 1974 "to promote the interest of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983) (surveying Congressional statements of purpose). However, with the rise of managed care and the Supreme Court's series of decisions holding preempted any action for damages against HMOs, ERISA has evolved into a shield that

insulates HMOs from liability for even the most egregious acts of dereliction committed against plan beneficiaries, a state of affairs that I view as directly contrary to the intent of Congress. Indeed, existing ERISA jurisprudence creates a monetary incentive for HMOs to mistreat those beneficiaries, who are often in the throes of medical crises and entirely unable to assert what meager rights they possess.

Lower courts have struggled to maintain some semblance of equity notwithstanding the enormous breadth of the preemption test, one that turns on whether the claim is "related to" a benefit plan, *inter alia*, by identifying exceptions to § 514 preemption, such as that for medical malpractice liability. And in terms of the remedial scope of § 502, they have struggled to make sense out of the distinction between eligibility decisions (which are preempted) and medical decisions (which are not), a hopeless endeavor, as I shall explain. Unfortunately, the price of all this has been descent into a Serbonian bog[1] wherein judges are forced to don logical blinders and split the linguistic atom to decide even the most routine cases.

I.

A.

ERISA was enacted in 1974 to address the increasingly-apparent insecurity of workers' vested pension funds, a problem that gained national recognition through such notorious events as the Studebaker plant shutdown in 1963,

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[1] A Serbonian bog is a mess from which there is no way of extricating oneself. E. Cobham Brewer, *The Dictionary of Phrase and Fable* 1121-22 (First Hypertext ed.). The Serbonian bog itself was between Egypt and Palestine. Strabo called it a lake, and said it was 200 stadia long, and 50 broad; Pliny made it 150 miles in length. Hume said that whole armies have been lost therein, as did Milton: "A gulf profound as that Serbonian bog, / Betwixt Damiata and Mount Cassius old, / Where armies whole have sunk." Milton, *Paradise Lost*, ii. 592.

which caused approximately 4,400 workers to lose their pensions. *See generally* Michael S. Gordon, *Overview: Why Was ERISA Enacted?*, U.S. Senate, Special Comm. on Aging, The Employee Retirement Income Security Act of 1974: The First Decade 6-25 (Information Paper) (1984). Prior to ERISA, workers were entitled only to the assets in the pension plan or to nominal pension benefits, whichever was lower; of course, it was entirely possible for a plan to have zero assets, as happened with some frequency when firms closed shop. ERISA contained a raft of provisions designed to protect plan participants against negligent or malfeasant plan managers. For example, it created the Pension Benefit Guarantee Corporation ("PBGC"), an insurer akin to the Federal Deposit Insurance Corporation, to protect against employer insolvency.

The "benefit plans" in need of protection, however, were of two distinct types–pension and welfare–and substantially different policy concerns animated Congress's reform in each area. Pension plans, to which employees contribute over the course of their careers and rely upon to provide retirement income, were thought to present far greater opportunity for mismanagement and underfunding. Unlike welfare benefit plans, pension plans accrue substantial funds that must be invested with prudence, and they must be able to survive continuously changing circumstances. Title 1 of ERISA therefore imposed on pension plan managers comprehensive reporting, disclosure, vesting, minimum funding, and fiduciary duty requirements.

Welfare benefit plans, which include medical, surgical, sickness, accident, disability, death, unemployment, and similar programs, posed a very different set of challenges. Unlike pension plans, welfare benefit plans operate on a "pay as you go" basis, and generally do not entail long-term financial commitments. *See* John H. Langbein and Bruce A. Wolk, *Pension and Employee Benefit Law* at 176 (3d ed. 2000). ERISA's framers therefore saw no need to impose

vesting requirements on such plans. Similarly, minimum funding requirements are intended to guard against plan default by the plan sponsor on its long-term commitments to plan beneficiaries, a minor concern where no substantial funds accrue. The framers thus exempted welfare benefit plans from ERISA's funding requirements as well.

The result is that welfare benefit plans are far less regulated than pension plans. They are subject to ERISA's reporting, disclosure, fiduciary, and remedial rules–those that govern procedure–but exempt from the substantive vesting and funding requirements, which are meant to guarantee a certain level of expected benefits. Congress's relative lack of concern with substantive regulation of welfare plans is clear from the Supreme Court's statement that "ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits." *Shaw*, 463 U.S. at 91. Indeed, courts have held that the absence of a vesting provision allows employers to amend their plans virtually at will, even in discriminatory fashion. *See, e.g. Confer v. Custom Engine Co.*, 952 F.2d 41, 43 (3d Cir. 1991) (noting a plan sponsor may change benefits prospectively by formal written notice); *McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991) (upholding an employer's amendment of its plan to exclude coverage for AIDS treatment).

Despite ERISA's relatively light regulation of welfare benefit plans, it is clear that the legislation provided substantially greater safeguards for both pension and welfare plan beneficiaries than had previously existed. But ERISA also contained a crucial concession to plan sponsors in the form of § 514(a), an express preemption provision mandating that Titles I and IV of ERISA, which impose the regulations discussed above, "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." Although this section is subject to

an important exception that allows states to impose laws regulating insurance, *see* § 514(b)(2)(A), its breadth is striking. The Supreme Court explains that Congress intended

> to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990). This view is premised on the statement of Rep. John Dent, a sponsor of the Act in the House of Representatives, who declared that its purpose was to "eliminat[e] the threat of conflicting and inconsistent State and local regulation." 120 Cong. Reg. 29197 (1974).

B.

In a meaningful sense, Congress's decision to federalize pension and employee benefit law appear to have assisted plan beneficiaries as much as plan sponsors. No employer is required to offer a pension or welfare benefit plan to its employees, and were Congress to have established ERISA's regulations as merely a federal baseline and allowed states to supplement it as they saw fit, i.e., had ERISA not preempted state law, some employers might have declined to offer such plans rather than deal with the compliance costs of tailoring them to individual jurisdictions. At a minimum, it is likely that any compliance costs would have been reflected in a lower level of benefits for plan participants, which of course would undermine the purpose of ERISA. From an *ex ante* perspective, therefore, it might have been reasonable to view even § 514(a) as furthering the interests of plan beneficiaries.

In practice, however, nothing has been further from the truth–ERISA generally, and § 514(a) particularly, have become virtually impenetrable shields that insulate plan sponsors from any meaningful liability for negligent or malfeasant acts committed against plan beneficiaries in all too many cases. This has unfolded in a line of Supreme Court cases that have created a "regulatory vacuum" in which virtually all state law remedies are preempted but very few federal substitutes are provided. In these cases, which began with *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), the Court initially employed textualist interpretations of § 514(a) to give ERISA a staggeringly broad preemptive scope. *Alessi* itself was a relatively straightforward case in which a unanimous Court held preempted a New Jersey law that eliminated one method for calculating pension benefits, reasoning that, whatever the law's purpose, it clearly related to pension plans. *Id.* at 524. Although *Alessi* itself was innocuous enough, it established a precedent of determining ERISA's preemptive scope by searching the phrase "relates to" for concrete meaning, an approach that would eventually be chimerical.

In *Shaw v. Delta Air Lines*, 463 U.S. 85 (1993), another unanimous decision, two New York statutes required health and disability plans to treat pregnancy the same as other nonoccupational disabilities at a time when federal employment discrimination statutes did not. In a landmark passage, the Court stated:

> We have no difficulty in concluding that the [New York laws] "relate to" employee benefit plans. The breadth of § 514(a)'s pre-emptive reach is apparent from that section's language. *A law "relates to" an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.*

Id. at 96-97 (emphasis added). Although the Court left the door ajar by cautioning that "[s]ome state actions may affect

employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan," *id.* at 100, n.21, the "connection with or reference to" language became the test for future cases.

The Court applied the passage in unanimous holdings in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (holding that a state statute mandating mental health coverage in group health insurance policies fell within § 514(a)'s preemptive scope, but was saved by ERISA's insurance exception), and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (holding preempted a state cause of action against an insurer for bad-faith denial of a claim). By the mid-1990s, however, it had become clear that the "relates to" standard was one without conceptual limits, and given the Court's general "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress," *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947), it balked at the specter of a preemptive vortex that could swallow virtually any state remedial law. It abruptly reversed course in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), where it unanimously noted that, "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for really, universally, relations stop nowhere." *Id.* at 655 (internal citation omitted). It recognized that it "simply must go beyond the unhelpful text . . . and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 656.

C.

As discussed above, Congress's intent behind § 514(a) preemption was to ensure that plan sponsors would be subject to uniform law. *See Ingersoll-Rand*, 498 U.S. at 142. One critical aspect of this uniformity concerns § 502,

ERISA's civil enforcement provision. In *Pilot Life,* the Court concluded that Congress intended the remedies in § 502 to be the *exclusive* remedies for violations of rights guaranteed under ERISA. It explained that "the pre-emptive force of § 502(a) was modeled on the exclusive remedy provided by § 301 of the Labor Management Relations Act. . . . Congress was well aware that the powerful pre-emptive force of § 401 of the LMRA displaced" all state law claims, "even when the state action purported to authorize a remedy unavailable under the federal provision." 481 U.S. at 52 53. In other words, § 514(a) preempts state causes of action to enforce ERISA-guaranteed rights even when § 502 provides no substitute federal cause of action. This "regulatory vacuum" creates situations in which plan beneficiaries have little or no recourse for even the most egregious violations of their rights, for the remedies contained in § 502 are incapable of making victims whole; indeed, in many cases they actually create incentives for HMOs to mistreat their plan participants.

Section 502 contains two subsections that address a participant's right to recover for wrongs committed against the participant personally (as opposed to those committed against the plan itself, which are considered violations of the sponsor's fiduciary duty). The first, § 502(a)(1)(B), authorizes the participant or beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." It is through this provision that DiFelice might have sought an injunction to compel Aetna to cover the specialized tracheostomy tube. The second, § 502(a)(3), authorizes a participant, beneficiary, or fiduciary to seek equitable remedies–injunctive relief against "any act or practice which violates" ERISA or the plan terms, or "other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions" of ERISA or the plan.

Although these provisions seem comprehensive at first glance–they allow recovery of "benefits due" and empower a participant to "enforce his rights" and seek "appropriate equitable relief "–they in fact operate to leave participants almost completely at the mercy of HMOs. The first section, 502(a)(1)(B), by its plain language only allows plan participants to seek the benefits to which they are contractually entitled, even when those benefits have been denied in bad faith and despite the fact that the participants most in need of this section are often the ones least able to take advantage of it. A plan participant whose claim is denied by an HMO's utilization review board–Mr. DiFelice, for example, see *infra*–is often in the throes of a life-or-death medical crisis, hardly a feasible time to retain counsel and prosecute an injunctive lawsuit. The costs of such suits are likely to be immense, and ERISA provides for attorney fees, if at all, only after the action concludes. *See* § 502(g)(1). Even if a participant ultimately prevails against his insurer, it will frequently be the participant's estate that reaps the meager reward.

In many areas of law contingency fee structures are used to overcome a litigant's initial impecuniosity. But any possibility of using contingency fees in this context is undermined by ERISA preemption, for a string of Supreme Court cases has interpreted ERISA to disallow any recovery of compensatory or punitive damages. *See* Langbein & Wolk, *Pension and Employee Benefit Law* at 770-75. In *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985), the plaintiff sued under § 502(a)(2), alleging that the improper processing of her benefit claim exacerbated her condition and entitled her to compensatory and punitive damages under § 409(a), which, *inter alia*, authorizes "such . . . equitable or remedial relief as the court may deem appropriate." The Court, however, concluded that any recovery under § 409 must inure to the plan rather than the beneficiary. The Court then explained in dictum that § 502(a)(1)(B), the analogous section allowing for a

participant's recovery, says "nothing about the recovery of extra-contractual damages." *Id.* at 144. In an oft-cited passage, it explained:

> The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted [ ] provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly. The assumption of inadvertent admission is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a comprehensive and reticulated statute.

Id. at 146 (internal citation omitted).

Although *Russell*'s narrow holding left open the possibility that extracontractual damages are recoverable under § 502(a)(3)'s "appropriate equitable relief" provision, the Court's subsequent decision in *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), foreclosed any such hopes. In *Mertens*, participants sued the fiduciaries of a failed plan, alleging breach of fiduciary duty and seeking monetary relief, which they characterized as equitable. Petitioners argued that, "[a]lthough a beneficiary's action to recover losses resulting from a breach of duty superficially resembles an action at law for damages, . . . such relief traditionally has been obtained in the courts of equity and therefore is, by definition, equitable relief." *Id.* at 255-56.

The Supreme Court acknowledged that ERISA's roots lie in the common law of trusts, *see Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-11 (1989), that courts of equity had jurisdiction over trust law, and that monetary damages were available in those courts against the trustee. It concluded, however, that "[s]ince *all* relief available for breach of trust could be obtained from a court of equity, limiting the sort of relief available under § 502(a)(3) to 'equitable relief' in the sense of 'whatever relief a common

law court of equity could provide in such a case' would limit the relief *not at all*." *Mertens*, 508 U.S. at 257. Put another way, interpreting "equitable relief" to mean "any relief" would render superfluous the word "equitable." The Court's solution was to interpret "equitable" as referring to types of relief traditionally available in pre-merger courts of equity, that is, injunctions, mandamus, and restitution, but not monetary damages.

The unavailability of extracontractual damages has effects that are perverse. First, as stated above, contingency fees are rendered entirely impractical–precious few lawyers would be willing to undertake a horrendously complex case of uncertain outcome when the greatest potential reward is merely provision of the care that had been contractually promised. Without contingency fees, participants in the midst of medical crises are completely at the mercy of HMOs unless they are fortunate enough to have the financial means to bring a suit for an injunction, a circumstance which is no doubt exceptional. Although it might seem a simple matter to seek an injunction compelling contractually-guaranteed coverage of a procedure, nothing is further from the truth where–as with Mr. DiFelice–the contractual availability of coverage hinges on a highly fact-intensive determination of medical necessity involving accepted standards of care and tolerable levels of risk for the participant's malady. To the extent that participants are unable to seek an injunction compelling coverage, ERISA's remedial scheme is almost entirely illusory.

The second perverse effect is that, at the same time as ERISA makes it inordinately difficult to bring an injunction to enforce a participant's rights, it creates strong incentives for HMOs to deny claims in bad faith or otherwise "stiff" participants. ERISA preempts the state tort of bad-faith claim denial, *see Pilot Life*, 481 U.S. at 54-56, so that if an HMO wrongly denies a participant's claim even in bad faith, the greatest cost it could face is being compelled to cover the

procedure, the very cost it would have faced had it acted in good faith. Any rational HMO will recognize that if it acts in good faith, it will pay for far more procedures than if it acts otherwise, and punitive damages, which might otherwise guard against such profiteering, are no obstacle at all. Not only is there an incentive for an HMO to deny any particular claim, but to the extent that this practice becomes widespread, it creates a "race to the bottom" in which, all else being equal, the most profitable HMOs will be those that deny claims most frequently.

In sum, ERISA's remedial scheme gives HMOs every incentive to act in their own and not in their beneficiaries best interest while simultaneously making it incredibly difficult for plan participants to pursue what meager remedies they possess, a confounding result for a statute whose original purpose was to protect employees.

II

A.

Given that ERISA's remedial scheme often provides no remedies, litigants have gone to great lengths to identify state causes of action that are not preempted by ERISA, and courts have generally been sympathetic to their efforts even when ultimately finding their claims preempted. For example, in *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49 (D. Mass. 1997), a clearly frustrated court inveighed:

> Under traditional notions of justice, the harms alleged–if true–should entitle [plaintiff] to some legal remedy on behalf of herself and her children against Travelers and Greenspring. Consider just one of her claims–breach of contract. This cause of action–that contractual promises can be enforced in the courts–pre-dates Magna Carta. It is the very bedrock of our notion of individual autonomy and property rights. It was among the first precepts of the

> common law to be recognized in the courts of the Commonwealth and has been zealously guarded by the state judiciary from that day to this. Our entire capitalist structure depends on it.
>
> Nevertheless, this Court had no choice but to pluck [plaintiff 's] case out of the state court in which she sought redress (and where relief to other litigants is available) and then, at the behest of Travelers and Greenspring, to slam the courthouse doors in her face and leave her without any remedy.

Id. at 52-53.

It is no exaggeration to say that the federal courts have struggled mightily to maintain fidelity to ERISA's expansive "relates to" preemption clause while avoiding the wholesale foreclosure of participants' causes of action against their HMOs. But our search for a middle ground has proved to be a judicial snipe hunt, and we are no closer to success today than we were a decade ago. This Court's own decisions illustrate the quagmire in which courts find themselves. In *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3d Cir. 1995), a participant sued his HMO alleging medical malpractice, a state-law tort, and the HMO argued that the claim was preempted by ERISA. We held that the claim was not preempted, reasoning that ERISA draws a distinction between actions challenging the *quality* of care provided and those claiming that the HMO provided an inadequate *quantity* of benefits under its plan. As we explained, actions challenging the *quantity* of benefits received are actions that could be brought under ERISA § 502(a)(1)(B) to "recover benefits due . . . under the terms of the plan," and any state law duplicating that remedy is preempted by ERISA § 514(a). Regulation of *quality* of care, conversely, was found to be "a field traditionally occupied by state regulation," *id.* at 357, and we did not find "anything in the legislative history, structure, or purpose of ERISA

suggest[ing] that Congress viewed § 502(a)(1)(B) as creating a remedy for a participant injured by medical malpractice." *Id.*

We further explicated this quantity-quality distinction in *In re U.S. Healthcare*, 193 F.3d 151 (3d Cir. 1999), which concerned, *inter alia*, a plan participant's claim that her HMO was negligent in adopting a policy of presumptively discharging newborn infants within 24 hours. We "recognize[d] that the distinction between the quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear," *id.* at 162, and explained that the line-drawing difficulty arises in part "because the same HMO may have assumed both the role as a plan administrator and the separate role as a provider of medical services." *Id.* The policy of discharging newborns after 24 hours was, however, determined to be a function of the "role as provider of medical services" because it was an "essentially medical determination of the appropriate level of care . . . , not a claim that a certain benefit was requested and denied." *Id.* at 162-63. We therefore held that the plan participant's claim "fit[ ] squarely within the class of claims that we identified in *Dukes* as involving the quality of care" and was not preempted. *Id.* at 163.

Finally, in our most recent and important ERISA preemption decision, *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), harm was allegedly caused by an HMO's delay in approving a procedure to be performed by off-network physicians. There was no question whether the treatment itself was covered–the issue was merely one of eligibility, namely whether an off-network physician could perform the procedure. We took note of the Supreme Court's recent decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000), where the Court distinguished between an HMO's eligibility decisions and treatment decisions. Although *Pegram* directly concerned fiduciary duty rather than preemption, we held that its eligibility-treatment dichotomy

was equally applicable in the preemption context; indeed, we considered it another way of viewing the quantity-quality distinction. We concluded that an eligibility decision is an administrative decision, and that any state-law action challenging it is preempted because a participant could instead bring suit under ERISA § 502(a)(1)(B) "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his right to future benefits under the terms of the plan." Conversely, a treatment decision is a medical decision that requires no interpretation of the plan itself, and it is not preempted by ERISA since § 502(a)(1)(B) offers a plaintiff no avenue of relief.

B.

I believe that *Dukes*, *In re U.S. Healthcare*, and *Pryzbowski* were all rightly decided, and that our opinion today reaches the correct conclusion based on those precedents. I write separately, however, to make clear my concern that the opinion masks extraordinary subtleties and complexities of this area of the law that cry out for clarification by the Congress, or, failing that, by the Supreme Court. In fact, I believe that the fundamental distinction upon which federal caselaw currently relies–between quantity and quality decisions, or between eligibility and treatment decisions–is untenable, and that the blurring is becoming more severe, not less. To the extent we insist on categorizing every HMO decision as *either* an eligibility *or* a treatment decision, we contort ourselves into parsing terms that are conceptually indistinguishable, and we fail to come to terms with the realities of modern health coverage.

This problem is evident even among relatively "easy" cases. *Pryzbowski* is perhaps one of the clearest-cut examples of an eligibility decision, for the HMO's only action was designing its plan to utilize network doctors, a clear matter of plan administration. Conversely, when one thinks of "treatment" or "medical" decisions, one envisions a

physician and an examination table, a world seemingly far removed from the HMO's administrative offices. Yet even in *Pryzbowski*, it takes little creativity to recast the "administrative" matter of plan design as a "treatment" or "medical" decision, for the HMO implicitly determined that requiring plan participants to see network physicians would not expose them to any undue health risks. It is impossible to characterize that decision as anything other than partially medical, for it directly affected participants' health. Indeed, the delay occasioned by the HMO's so-called "administrative decision" quite literally caused Ms. Pryzbowski's condition seriously to worsen.

The Supreme Court itself recognized this false dichotomy problem in *Pegram*, where it observed that many (and possibly most) HMO decisions contain elements of both eligibility and treatment considerations:

> [A] great many and possibly most coverage questions are not simple yes-or-no questions, like whether appendicitis is a covered condition (when there is no dispute that a patient has appendicitis), or whether acupuncture is a covered procedure for pain relief (when the claim of pain is unchallenged). The more common coverage question is a when-and-how question. Although coverage for many conditions will be clear and various treatment options will be indisputably compensable, physicians still must decide what to do in particular cases. The issue may be, say, whether one treatment option is so superior to another under the circumstances, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement. . . . In practical terms, these eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment.

530 U.S. at 228-29.

Some courts have attempted to explain away the evident problems in the "eligibility versus treatment" dichotomy by

holding that only HMOs which employ their own physicians can make medical decisions. *See, e.g., Rubin-Schneiderman v. Merit Behavioral Care Corp.*, 163 F. Supp. 2d 227 (S.D.N.Y. 2001). Such courts suggest that HMOs which do not directly employ physicians cannot engage in "mixed" decisions because they do not actually treat patients. The Supreme Court itself has cast doubt upon this explanation, stating that decisions are considered "mixed" "not merely because . . . treatment and eligibility are made by the same person, the treating physician." *Pegram*, 530 U.S. at 228. But this distinction is logically tenuous even absent that precedent, for an HMO that employs no physicians must nevertheless review the independent physicians' recommendations to determine whether they comport with the health plan's requirements.

The case at bar makes evident the impossibility that any such simple rule can adequately reflect the Byzantine complexities of modern-day health care. AETNA's policy explicitly equated its coverage (i.e., eligibility) on an assessment of medical necessity. But the medical necessity clause, which attempts to convert medical decisions into eligibility decisions, compounds the problem I address herein. Indeed, Aetna denied coverage even though Dr. Picariello insisted the specialized tracheostomy tube was critical to DiFelice's health. Tracheotomy is an extremely serious procedure, and the tracheostomy tube, whose uses are described in the margin, is an integral part of the procedure.[2] As two prominent medical school professors

---

[2] The purposes of a tracheotomy tube are: (1) to provide secure continuation of the airway through the passage of the soft tissues of the neck; (2) to offer a possibility of artificial pressure ventilation if needed; and (3) to seal the trachea to prevent aspiration of material above the tube or in the hypopharynx. *See* Carl-Eric Lindholm, *Choice of Tracheostomy Tube*, Tracheotomy 125 (Churchill Livingstone 1985).

explain, tracheotomy "is associated with multiple and potentially life-threatening complications even under elective conditions." Eugene N. Myers and Ricardo L. Carrau, *Early Complications of Tracheotomy: Incidence and Management*, 12 Clinics in Chest Medicine No. 3 at 589 (September 1991). Indeed, "[e]ven with the use of optimal surgical techniques, complications of tracheotomy may occur during the procedure, in the immediate postoperative period, or long after the surgery." Eugene N. Myers and Sylvan E. Stool, *Complications of Tracheotomy*, Tracheotomy 147 (Churchill Livingstone 1985). They counsel that "[t]he best means of preventing complications whenever they occur [ ] are paying meticulous attention to detail in the performance of the surgery and performing the tracheotomy as soon as it becomes obvious that the procedure is necessary." *Id.*

This assessment is borne out by the history of DiFelice's condition. In March of 2001, DiFelice was diagnosed with sleep and upper airway obstruction. His otolaryngologist, Dr. Michael Picariello, attempted several unsuccessful treatments before determining that DiFelice needed a tracheostomy tube. Dr. Picariello surgically placed a tracheostomy tube in July of 2001, but it continually extubated from DiFelice's neck. It was only then that Dr. Picariello determined that DiFelice needed a specially-designed tube to remedy a potentially life-threatening condition.

Aetna, however, overruled Dr. Picariello's expert medical judgment and determined that the tube was in fact not medically necessary, leaving DiFelice with the option of bringing an injunctive suit under ERISA § 502, paying out-of-pocket for the specially-designed tube, or receiving a second standard-shaped tube that Aetna agreed to cover. He opted for the covered tube, but after it was placed, he developed a serious and progressive soft tissue and bone infection that caused him to be admitted to Chester County hospital in October of 2001, following which he was referred

to the Hospital at the University of Pennsylvania. There, doctors removed "significant portions" of his bone and tissue to treat the infection, and his pectoral muscle was surgically reconfigured.

Aetna claims that its decision was not medical merely because it was made with an eye to plan language. To me this makes no sense, for Aetna made precisely the same individualized determination of medical necessity as Dr. Picariello. The fact that Aetna is an HMO and Dr. Picariello is an independent physician is entirely irrelevant to the fundamental character of their assessments. My conclusion that Aetna's decision may have been largely medical suggests that perhaps DiFelice's claim *should not* be preempted. Such a result would follow comfortably under *Dukes* and *In re U.S. Healthcare*. I agree with Judge Rendell, however, that Supreme Court precedent compels the conclusion that the proper test is whether a suit is theoretically possible under § 502(a), an approach which leads to preemption under the facts of this case.

Judge Rendell's opinion recognizes that Aetna's decision had a medical component. It declines to characterize it as either eligibility or treatment, and concludes that in such mixed situations, preemption turns on the availability relief under ERISA § 502(a). This resolution at least has the salutary effect of creating a bright-line rule, perhaps the best we can hope for absent intervention from a higher authority that would enable a truly principled jurisprudence. But while this rule is relatively easy to apply, that ease comes at the direct expense of plan participants' welfare. The rule's premise is that HMOs that do not employ their own physicians are solely in the insurance business, that is, they do not provide care and cannot be medically negligent. In the opinion's words, "because there is no allegation that Aetna actually provided the medical care, Aetna's use of medical judgment could only have led to an eligibility, not a treatment, decision." I believe that this statement (with

which I do not agree) encapsulates precisely why ERISA's failure to change with the times has rendered it incapable of protecting employees, and why Congress must act to prevent further injustice.

C.

As discussed above, existing Supreme Court precedent holds that ERISA disallows extracontractual damages even in instances of bad faith, an interpretation that gives safe harbor to HMOs that deny claims while also destroying any possibility of participants bringing § 502 actions under contingency fee arrangements. The result is that, in many cases, participants must take HMOs' decisions as law–for example, when Aetna's utilization review board denied coverage for DiFelice's specialized tracheostomy tube, he faced the decision whether to pay for the specialized tube out-of-pocket, whereas appealing the HMO's decision was simply impractical in the face of a medical emergency. In such cases, the critical insight is that the HMO *de facto* determines a patient's *actual treatment* along with his eligibility for benefits, for it will be a relatively rare person who is able to pay for invasive procedures out-of-pocket.

Because ERISA creates a system in which an HMO's benefit determination frequently determines the actual treatment a participant receives, it follows directly that HMOs determine quality of care–and make treatment decisions–regardless of whether they actually employ physicians. Put differently, the root of courts' ERISA preemption nightmare is that ERISA forces them to distinguish between eligibility and treatment decisions while providing a remedial structure that makes the two virtually synonymous. For participants, the torment is still greater: ERISA *de facto* places the HMO in control of the treatment a participant receives, yet it preempts any state-law medical malpractice claim against that HMO and provides that the participant can recover no compensatory, punitive, or wrongful-death damages regardless of its malfeasance.

This situation has arisen because ERISA has failed to evolve to accommodate the rise of HMOs, which did not even exist when ERISA was enacted in 1974. Back then, fee-for-service insurers dominated the health care industry. *See Pegram*, 530 U.S. at 218; *see also* Kent G. Rutter, *Democratizing HMO Regulation to Enforce the "Rule of Rescue"*, 30 U Mich. J. L. Ref. 147, 171 (1996). Insurers had little role in a person's treatment decisions; instead, a participant would visit a doctor or hospital, receive treatment, and the doctor or hospital would bill the insurer. If an insurer refused to pay, the participant could bring suit under ERISA § 502(a) to recover benefits due under the terms of the plan. This was the role Congress envisioned for § 502, and it worked well, for any disagreement with an insurer would occur only after the participant's medical crisis had abated, and in some ways the system created an incentive to provide too much care rather than too little.

Times have changed. Today, approximately 75% of insured American workers receive their heath care through some type of "managed care" plan, a designation which includes HMOs. *See* Andy Miller, *Managed Care Savings Noted*, Atlanta J. & Const., June 5, 1997, at E3. One hallmark of managed care systems is the utilization review board, which approves or denies coverage for a procedure before the procedure actually takes place. Although a participant may appeal a utilization review board's decision, the prior-approval system is thought to reduce costs to HMOs because participants are likely to choose an inferior (but approved) procedure over a superior procedure for which they might ultimately pay out-of-pocket following an unsuccessful appeal. ERISA is often ill-equipped to deal with the phenomenon of the utilization review board, for the lack of remedies available under § 502, as discussed above, actively encourages HMOs to deny claims. Because these denials now take place before the treatment itself, the effect is a systematic deterioration in the quality of treatment participants receive, all oxymoronically occasioned by a

statute "designed to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw*, 463 U.S. at 90.

III.

What is to be done? Not much, absent intervention by Congress or the Supreme Court, for lower courts are bound to follow precedents that lead inexorably to the "availability of § 502 relief" preemption test set forth by the majority opinion in this case. However, several promising avenues exist. One is suggested by the Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2723, 106th Cong., 1st Sess. (1999), which passed the House but was watered down in the Senate. *See Langbein & Wolk*, Pension and Employee Benefit Law at 561-62. That Act would have amended ERISA § 514 by adding a new subsection (e) providing that ERISA shall not:

> be construed to invalidate, impair, or supercede any cause of action brought by a participant or beneficiary (or the estate of a participant or beneficiary) under State law to recover damages resulting from personal injury or for wrong death against any person–
>
> (i) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health [plan], or
>
> (ii) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.

The Act would have disallowed punitive damages when the cause of action relates to an "externally appealable decision." It set up such external appeal procedures for denials of benefit claims based on decisions that "the item or service is not medically necessary or appropriate or is investigational

or experimental" or "in which the decision as to whether a benefit is covered involves a medical judgment."

Put more concretely, had the Act become law, Aetna would now face possible compensatory damages but not punitive damages, and its determination of medical necessity would be externally appealable. Although the Act passed the House, it did not survive in the Senate, which passed a version of health care reform containing no right to sue. *See* H.R. 2990, 106th Cong., 1st Sess. (1999). As suggested, the legislation approved by the House is one approach. There are doubtless others.

Even if Congress refuses to act, however, the Supreme Court, in its interpretive capacity, is capable of effecting salutary change in many ways. The Court has no crystal ball, and twenty years ago it could not have foreseen the radical changes that have overtaken the health care system, and the difficulties that its preemption decisions would create. The time might be right to reconsider the string of holdings, epitomized by *Russell* and *Mertens*, that rule out the possibility of recovering compensatory damages under ERISA § 503(a)(3). *See generally* John H. Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in* Russell, Mertens, *and* Great-West, Yale Law School Center for Law, Economics, and Public Policy, Research Paper No. 269, available online at *www.ssrn.com*. Professor Langbein persuasively argues: (1) that the Supreme Court erred in interpreting ERISA's language providing for "other appropriate equitable relief" to mean only relief that was traditionally available in courts of equity; and (2) that the better view is that Congress intended "to remedy ERISA wrongs of the sort commonly remedied under trust law," and a core principal of trust law, the "make-whole standard," attempts to "restore[ ] the victim to the position that he or she would have had had there been no breach of trust."

That is precisely what compensatory damages do, and there is no reason to suspect that Congress intended to base

ERISA on the law of trusts while omitting the predicate law's core remedy. I note that I am not alone among federal judges in urging the Supreme Court to reconsider what has become a significant barrier to justice and the realization of Congressional intent. *See, e.g., Cicio v. Does*, 321 F.3d 83, 107 (2d Cir. 2003) (Calabresi, J., dissenting) ("[I]t is not too late for the Supreme Court to retrace its Trail of Error and start over from the beginning, or for Congress to wipe the slate clean."). *Cf. Corcoran v. United Healthcare*, 965 F.2d 1321, 1336 (5th Cir. 1992) ("The characterization of equitable relief as encompassing damages necessary to make the plaintiff whole may well be consistent with the trust law principles that were incorporated into ERISA and which guide its interpretation.").

Another possibility for the Supreme Court, especially given its recent trend toward looking beyond the text of § 514(a) to determine ERISA's preemptive scope, is to rexamine Congress's intent (or lack thereof) with respect to preempting welfare benefit plans. Many scholars have noted that Congress did not carefully consider the scope of preemption when it drafted ERISA. *See, e.g.*, Fick, *The Last Article about the Language of ERISA Preemption?*, 33 Harv. J. on Legis. 35, 53 (1996). The House bill would have preempted state laws that "relate to the reporting and disclosure responsibilities and fiduciary responsibilities of persons acting on behalf of" ERISA-covered plans, and state laws that "relate to" funding and benefits-vesting provisions of pension plans. H.R. 2, 93d Cong., 1st Sess. (1973), 120 Cong. Rec. 4742 (1974). The Senate version, on the other hand, would have preempted state laws that "relate to the subject matters regulated by this Act." S. 4200, 93d Cong., 1st Sess. (1973), 120 Cong. Rec. 5002 (1974).

In the final joint conference, the Committee adopted the present language, but made it available to the full Congress only ten days before the bill was enacted, and said little about the change. *See Metropolitan Life Ins. Co.*, 471 U.S. at

745 n.23. There is scant reason to believe that the resulting language was fully considered by the entire deliberative body; indeed, those who paid attention to the issue opined that § 514(a) was provisional. Section 3022 mandated the creation of a Joint Pension Task Force to study the practical effect and desirability of preemption, and Senator Jacob Javits, a sponsor of the legislation, said that "the desirability of further regulation–at either the State or Federal level–undoubtedly warrants further attention." 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits). Unfortunately, the Task Force never came into existence, and no further regulation was forthcoming.

The evidence suggests that Congress did not carefully consider whether the scope of preemption should reflect the different degrees of federal regulation of pension plans and welfare benefit plans. *See* Fisk, *The Last Article about the Language of ERISA Preemption?*, 33 Harv. J. on Legis. at 56. In my view, section 514(a)'s broad preemptive scope is sensible with regard to pension plans, for federal law fully displaces state law and provides vesting, requirements, minimum funding requirements, and a raft of other employee safeguards. However, to me, it makes much less sense with respect to welfare plans. As discussed *supra*, Congress exempted welfare benefit plans from most of ERISA's substantive regulations, such as its vesting and minimum funding requirements.

As I see it, it is unlikely that Congress intentionally created this so-called "regulatory vacuum," in which it displaced state-law regulation of welfare benefit plans while providing no federal substitute. The more likely explanation is that Congress merely intended to create minimum safeguards to protect the financial integrity of welfare benefit plans while stopping short of federalizing the entire remedial regime, especially in light of what was a workable state-law remedial system. Congress's failure to distinguish explicitly between pension and welfare benefit plans in § 514(a) is

understandable, for, as explained above, the managed care plans that wreak havoc with § 514(a) as it relates to welfare benefit plans did not exist when ERISA was enacted. There is no evidence that Congress envisioned the current situation.

Taking note of Congress's understandable lack of clairvoyance, the Supreme Court might embrace pragmatism and limit § 514(a)'s preemptive scope regarding welfare benefit plans. Although the distinction would find little support in the text of ERISA itself, Justices Scalia and Ginsburg recently admitted in a concurrence that:

> [A]pplying the 'relate to' provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else. The statutory text provides an illusory test, unless the Court is willing to decree a degree of pre-emption that no sensible person could have intended–which it is not.

California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc., 519 U.S. at 335-36 (1997) (internal citation omitted). Absent textual guidance or meaningful legislative history, there is little to prevent a pragmatic solution to a problem Congress has not confronted.

No doubt there are other possible solutions. The vital thing, however, is that either Congress or the Court act quickly, because the current situation is plainly untenable. Lower courts are routinely forced to dismiss entirely justified complaints by plan participants who have been grievously injured by HMOs and plan sponsors, all because of ERISA, the very purpose of which was to safeguard those very participants. Our dockets grow increasingly crowded with cases where participants offer myriad varieties of artful pleadings in their desperate attempts to circumvent ERISA's procrustean reach, and our caselaw grows massively inconsistent due to the sheer complexities of the subject and

lack of any meaningful guidance. There must be a better way.

The Clerk of Court is directed to send a copy of this opinion (with attention directed to the concurrence) to the Solicitor of the Department of Labor; the Chair, Ranking Member, Chief Majority Counsel, and Minority Counsel of the Senate Committee on Health, Education, Labor, and Pensions; and the Chair, Ranking Member, Chief Majority Counsel, and Minority Counsel of the House Committee on Education and the Workforce.

AMBRO, Circuit Judge, *concurring*:

Judge Rendell's opinion is well-crafted, and I join it. In many cases, however, the result underwhelms. Thus, like Judge Becker, I implore for a better way to make these kinds of decisions.

Congress in 1974 passed "a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Airlines, Inc.* 463 U.S. 85, 90 (1983). That statute–the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*–made policy compromises in order to combat exponentially rising health care costs in a melange of state tort laws assessing negligence after-the-fact. *See generally* Jonathan J. Frankel, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 Yale L.J. 1297 (1994). Among the newer forms of managing the providing of healthcare services was to "'prospectively and concurrently assess the appropriateness of care. . . .'" *Id.* at 1302 (quoting Elizabeth W. Hoy *et al.*, *Change and Growth in Managed Care*, HEALTH AFF., Winter 1991, at 27).

Instead of healthcare insurers reimbursing insureds for already-given medical care, health maintenance

organizations ("HMOs") were created where, upon "receipt of a fixed fee for each patient enrolled under the terms of a contract [,] . . . specified health care [is provided] if needed." *Pegram v. Herdrich*, 530 U.S. 211, 218 (2000). Physicians contract with HMOs to provide services to patients in the HMO for set fees. HMOs, via a health plan purchased by patients' employers, set "[r]ules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services. . . ." *Id.* at 223. The bottom line–non-routine medical services are provided after they are approved.

This system, simple in concept, has sisyphean frustration in application. At the forefront is preemption. To save costs in a tort system where medical decisions by service providers are second-guessed by non-medical persons, ERISA preempts state law that conflicts with ERISA, 29 U.S.C. § 1144(a), and is a "cause of action within the scope of the civil enforcement provisions of [ERISA] § 502(a) [29 U.S.C. § 1132(a)]." *Cicio v. Does*, 321 F.3d 83, 94 (2d Cir. 2003) (quoting from *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987)). Included within this subsection is any civil action brought "by a [plan] participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan. . . ." 29 U.S.C. § 1132(a)(1)(B). Stated colloquially, ERISA "federalizes" most employee benefit plan remedies.

Judges Rendell and Becker in this case, and Judge Calabresi in his partial dissent in *Cicio*, 32 F.3d at 106 *et seq.*, point out poignantly the so-often unsatisfying constructs we use to cipher meaning when cultures of cost containment and tort responsibility clash over preemption. "The litigants in these cases spar over the extent to which a lay financing entity [the HMO] has appropriated to itself distinctly *medical* authority by substituting its own expertise for that of the treating physician." Frankel, 103 Yale L.J. at

1303 (emphasis in text). I join the chorus calling for a fresh look from higher authority to promote better the primary Congressional purpose of ERISA–protecting plan participants and their beneficiaries. "At issue is nothing less than the definition of medical decisionmaking itself," *id.*, and the lives that this affects.

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No. 03-69

IN THE

Supreme Court of the United States

VYTRA HEALTHCARE AND BRENT SPEARS, M.D.,

Petitioners,

v.

BONNIE CICIO,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF OF *AMICI CURIAE* THE AMERICAN ASSOCIATION OF HEALTH PLANS, INC., THE HEALTH INSURANCE ASSOCIATION OF AMERICA, THE AMERICAN BENEFITS COUNCIL AND THE NEW YORK HEALTH PLAN ASSOCIATION IN SUPPORT OF PETITIONERS

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STATEMENT OF INTEREST[1]

The American Association of Health Plans, Inc. ("AAHP"), the Health Insurance Association of America ("HIAA"), the American Benefits Council (the "Council") and the New York Health Plan Association, Inc. ("NYHPA") (collectively "*Amici*") submit this brief in support of the Petitioners, Vytra Health Plans Long Island, Inc. and Brent Spears, M.D.

AAHP is the national association for the managed health care community. AAHP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy and the provision of services to member health plans. Its membership includes health maintenance organizations ("HMOs"), preferred provider organizations, third party health plan administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1000 managed health care organizations serving nearly 160 million Americans, the majority of whom are participants or beneficiaries of employee benefit plans covered by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.*

HIAA is based in Washington, D.C., and is one of the largest associations of health insurance companies in the world. HIAA is the nation's most prominent trade association representing the private healthcare system. Its nearly 300 members provide health, long-term care, dental, disability, and supplemental coverage to more than 100 million Americans. It is the nation's premier provider of self-study courses on health insurance and

1. Pursuant to this Court's Rule 37.3(a), letters of consent from all parties to the filing of this brief have been filed with the Clerk of the Court. Pursuant to this Court's Rule 37.6, *Amici* state that this brief was not authored in whole or in part by counsel for any party, and that no person or entity other than *Amici*, their members, or their counsel made a monetary contribution to the preparation or submission of this brief.

managed care. HIAA advocates a private, market-based health insurance system and is dedicated to promoting federal and state health care policies that maximize the quality, affordability, accessibility, and responsiveness of medical services provided to the nation's health care consumers.

The Council is a broad-based, non-profit trade association founded in 1967 to protect and foster the growth of this nation's privately sponsored employee benefit plans. The Council's members include both small and large employer-sponsors of employee benefit plans, including many Fortune 500 companies. Its members also include employee benefit plan support organizations, such as actuarial and consulting firms, insurers, banks, investment firms, and other professional benefit organizations. Collectively, its more than 250 members sponsor and administer plans covering more than 100 million plan participants and beneficiaries.

NYHPA is the New York State association for the vast majority of health plans offering coverage to residents of New York State. Its membership consists of HMOs, health insurers and prepaid health service plans that serve more than six million New Yorkers, as well as residents of neighboring states, the majority of whom are participants or beneficiaries of employee benefit plans under ERISA. NYHPA has worked closely with public policy officials to develop balanced and innovative approaches that increase health plan accountability for coverage decisions while maintaining affordable health care coverage.

REASONS FOR GRANTING THE PETITION

The foundation of this country's health insurance system is employer-sponsored health care coverage. *See* Employee Benefit Research Institute, *Special Report and Issue Brief, EBRI Research Highlights: Health Benefits* 5 (May 2003) ("Currently, employment-based health insurance is the most common form

of health coverage in the United States."). "Employer-sponsored healthcare reaches nearly two out of every three Americans, including active workers, retirees, and their dependents." The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2002 Annual Survey* 1 (2002). Employers do not sponsor this coverage because of a government mandate. Rather, employers voluntarily undertake the obligation to administer and pay for their employees' health benefits. The voluntary nature of employer-sponsored health care coverage, and the extent and continued vitality of this system, are a direct result of the policy choices Congress made when it adopted ERISA.

Indeed, Congress enacted ERISA in 1974 in large measure to induce employers to offer and maintain benefit plans for their employees. Congress recognized that uniform federal rules and oversight would encourage the growth of employee benefit plans. To allow employers to provide uniform benefits across all states without having to conform to varying state regulatory environments, Congress included two crucial provisions in ERISA: § 514(a) and § 502(a). 29 U.S.C. §§ 1144(a), 1132(a). The former is a broad preemption statute; the latter a civil enforcement provision that is the "exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987).

For years following this Court's decision in *Pilot Life*, employers made benefit decisions with the knowledge that ERISA preempted state law claims against benefit plans. Courts held that § 514(a) and/or § 502(a) preempted virtually all state claims, including those against plan administrators for making alleged medically-based eligibility determinations. As a consequence, employers were able to provide health care coverage to their employees without having to comply with fifty sets of state laws. Multi-state employee benefit plans were able

to treat similarly situated employees the same regardless of their state of residence. The environment was one in which incentives existed for employers to provide health benefits to their employees. In fact, by 2001, the percentage of workers covered by employment-sponsored health insurance grew to 73.7%. Employee Benefit Research Institute, *supra* 14.

But the stability and predictability in the law that existed since *Pilot Life* — and served the needs of both employers and employees (including union benefit plans) — is eroding because of decisions such as that of the court below in *Cicio v. Vytra*, 321 F.3d 83 (2d Cir. 2003). The Second Circuit's decision has created a cloud of uncertainty over the countless decisions that plan administrators must make every year and undermines the national uniformity of employee benefits plans. This is true not only for medical necessity decisions — whether an otherwise covered service is medically necessary for a given patient — but also for interpretations concerning explicit contract exclusions of experimental treatments, which, by definition, are not clinically proven and may even be dangerous.

Allowing state claims against plan administrators, even in cases where it is alleged that a decision reflects medical judgment, will now inject the ever-changing law of fifty different states into an area that has been governed exclusively by federal standards. Faced with different state liability rules, employee benefit plans will be forced to treat similarly situated employees differently based on the state in which the participant resides. Additionally, benefit plans will be forced to engage in costly risk management as they weigh the language of the benefits plan and the judgment of plan administrators against the risk of state law claims. Law suits will proliferate and employer costs will increase as benefit plans absorb increased litigation expenses.

Most importantly, a fifty-state patchwork scheme of ERISA enforcement will harm the people who Congress sought to protect — the 131 million Americans who participate in group health plans governed by ERISA, all of which are voluntarily sponsored. *See "Small Business Health Fairness Act": Hearing on HR. 660 Before the Subcom. On Employer-Employee Rel. of the House Comm. On Educ. & the Workforce*, 108th Cong. (Mar. 13, 2003) (statement of Ann. L. Combs, Ass't. Sec'y. for Employee Benefits Sec., U.S. Dep't of Labor) (stating that ERISA protects "approximately 2.5 million private, job-based health plans and 131 million workers, retirees and their families"). The cost of health care coverage will increase while its availability will decrease. Co-payments, co-insurance and deductibles will rise and plan benefits will be reduced or eliminated. *See Egelhoff v. Egelhoff*, 532 U.S. 141, 149-50 (2001) ("Requiring ERISA administrators to master the relevant laws of 50 states and to contend with litigation would undermine the congressional goal of 'minimizing the administrative and financial burdens on plan administrators' — burdens ultimately borne by the beneficiaries.").

The disuniformity created by the decision below is compounded by the confusion that now exists in the lower courts regarding the impact of this Court's decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000) on state-law claims such as the one at issue here. Like some other courts, the court below mistakenly relied upon the dicta regarding "mixed" treatment and eligibility decisions in *Pegram*. However, *Pegram* was not a preemption ruling and nowhere in that decision did this Court imply it was overruling *Pilot Life* and its progeny, which is controlling in this case.

Accordingly, this Court's review is needed to clarify its decision in *Pegram* and restore Congress' policy of inducing employers to provide voluntarily health care coverage to employees by ensuring the uniform administration of health benefits and the exclusivity of ERISA's remedy scheme.

I. THE DECISION BELOW UNDERMINES CONGRESS' POLICY OF INDUCING EMPLOYERS TO OFFER HEALTH BENEFITS

This Court's immediate review is necessary to settle the law in an area where uniformity and predictability are imperative. Congress intended that ERISA preemption would enable plan administrators to make eligibility determinations without having to refer to fifty sets of state laws. All this has now changed with the recent decisions of the court below and other lower courts. Such decisions undermine Congress' policy choice in ERISA of inducing employers to offer health benefits by ensuring the uniform administration of health benefits and the exclusivity of ERISA's remedy scheme.

After more than a decade of debate, Congress enacted ERISA in 1974 in large measure to encourage employers to offer and maintain benefit plans for their employees. *See* Michael S. Gordon, *Overview: Why Was ERISA Enacted?*, U.S. Senate, Special Comm. On Aging, *The Employee Retirement Income Security Act of 1974: The First Decade*, at 25 (Comm. Print 1984). Although ERISA comprehensively regulates such plans, it leaves in place the voluntary nature of plan sponsorship. *Compare Great-West Life and Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002) (noting that ERISA is a "'comprehensive and reticulated statute'"), *with* 29 U.S.C. § 1003(a) ("this subchapter shall apply to any employee benefit plan *if it is established or maintained*") (emphasis added). The existence of employee benefits — such as a health care program — is dependent upon employers' willingness to create employee plans.

Congress was mindful that, to the extent government regulation increased benefit plan costs, the result would be to encourage termination of existing plans and discourage

formation of new benefit plans. *See, e.g.*, 120 Cong. Rec. 4295 (1974) (remarks of Rep. Ullman) ("Generally, it would appear that the wider or more comprehensive the coverage, vesting, and funding, the more desirable it is from the standpoint of national policy. However, since these plans are voluntary on the part of the employer and both the institution of new pension plans and increases in benefits depend upon employer willingness to establish or expand a plan, it is necessary to take into account additional costs from the standpoint of the employer."). In order to further the "public interest in encouraging the formation of employee benefit plans," ERISA established uniform regulation and imposed federal oversight in this area. *Pilot Life*, 481 U.S. at 54; *see Egelhoff*, 532 U.S. at 148 ("One of the principal goals of ERISA is to enable employers 'to establish a uniform administrative scheme which provides a set of standard procedures to guide processing of claims and disbursement of benefits.'").

Congress also recognized that plans and their sponsors faced fifty sets of complex and conflicting state laws and regulations. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990) (stating that Congress' goal in enacting a preemption provision was to minimize "the administrative and financial burden of complying with conflicting directives among State or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction"). Finding that inconsistencies in laws and regulations resulted in administrative inefficiencies and costs that ultimately hurt plan participants, Congress concluded that "employee benefit plans would prosper best if regulated by the federal government without state involvement." William J. Kilberg & Paul D. Inman, *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 Tex. L. Rev. 1313, 1313-14 (1984); *see* H.R. Rep. No.

93-533, at 12 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650 ("The uniformity of decision which the act is designed to foster will help administrators, fiduciaries and participants to predict the legality of the proposed actions without the necessity of reference to varying state laws."). That policy judgment has been aptly summarized by this Court:

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants . . . [and] making disbursements. . . . The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to . . . process claims in a certain way in some States but not in others. . . .

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9 (1987). *See also Egelhoff*, 532 U.S. at 148 ("[u]niformity is impossible . . . if plans are subject to different legal obligations in different states").

Congress sought to achieve the goal of creating a uniform body of benefits law through a broad preemption clause. *See California Div. of Labor Standards Enforcement v. Dillingham Constr. N.A., Inc.*, 519 U.S. 316, 324 (1997) (reviewing the Court's many previous acknowledgements that ERISA's preemption provision is "clearly expansive," has a "broad scope," an "expansive sweep," is "broadly worded," deliberately expansive" and "conspicuous for its breadth"). Section 514(a) of ERISA preempts "any and all" state laws that "relate to" an employee benefit plan. 29 U.S.C. § 1144(a).

ERISA's legislative history highlights the intended broad scope of § 514(a) and Congress' concern with the negative effect that litigation would have on employee benefit plans. For example, Senator Jacob Javits, one of ERISA's authors, expressed concern that a narrow preemptive scope would increase the "possibility of endless litigation over the validity of State action that might impinge on Federal regulation," and that "[t]he emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans . . . required the displacement of State action in the field of private employee benefit programs." 120 Cong. Rec. 29,942 (1974). Congress hoped to avoid "opening the door to multiple and potentially conflicting State laws" by preempting them. *Id.*

Also, in lieu of a multiplicity of state remedies, Congress included a civil enforcement provision in § 502(a) of ERISA. 29 U.S.C. § 1132(a). Sixteen years ago, in *Pilot Life*, this Court held that the provisions of § 502(a) are the "exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." 481 U.S. at 52. The Court thus established a categorical rule: § 502(a) preempts any state-law claim that purports to provide different or additional judicial remedies for a wrongful denial of benefits. *Id.* at 54. Applying this rule, the Court found that § 502(a) preempted state-law contract and tort claims filed against an insurer for the "bad faith" denial of disability benefits. *Id.* at 55-56.

In the wake of *Pilot Life*, employee benefit plans were able to make health benefit decisions confident that they would not be subject to alternative state law remedies. Time and time again, the circuit courts recognized that ERISA sections 514(a) and/or 502(a) preempt state law claims that challenge an ERISA plan's claims decisions, including claims determinations based on plan provisions that limit coverage to medically necessary treatments or condition coverage on pre-certification. *See, e.g., Hull v.*

Fallon, 188 F.3d 939 (8th Cir. 1999), *cert. denied*, 528 U.S. 1189 (2000); *Danca v. Private Health Care Sys.*, 185 F.3d 1 (1st Cir. 1999); *Jass v. Prudential Health Care Plans, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Cannon v. Group Health Serv. Of Oklahoma*, 77 F.3d 1270 (10th Cir.), *cert. denied*, 519 U.S. 816 (1996); *Tolton v. American Biodyne*, 48 F.3d 937 (6th Cir. 1995); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992). For years, this stability in the law provided plan administrators with the certainty and predictability they needed to plan and administer health benefits budgets.

To be sure, this Court has revisited the scope of ERISA preemption since deciding *Pilot Life*. At no time, however, has the Court departed either from the core principle that § 514(a) preempts state laws and remedies that disrupt the uniform administration of an employee benefit plan or "*Pilot Life's* categorical preemption rule" under § 502(a). *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379-80 (2002). For example, in *New York State Conference of Blue Cross and Blue Shield Plans, Inc. v. Travelers Ins. Co.*, 514 U.S. 645 (1995), the Court narrowed the reach of preemption but, importantly, reaffirmed that "[t]he basic thrust of [ERISA's] preemption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 657. Whatever the outer limits of ERISA preemption might be, the Court reaffirmed that ERISA preempts state laws or causes of action that would undermine the uniform application of benefits. *Id.* at 668 (a state law that would "force an ERISA plan to adopt a certain scheme of substantive coverage" would likely be preempted under ERISA).

Travelers is of a piece with all of this Court's preemption decisions which have consistently emphasized the importance of uniformity and the preeminence of ERISA's enforcement mechanisms. Most recently, in *Rush Prudential HMO, Inc. v. Moran*, this Court again stated that ERISA preempts state laws or causes of action which supplement or add to the remedies

available under ERISA, holding that a law that "provided a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA . . . patently violates ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct." 536 U.S. at 379.

But the goals of predictability and uniformity that Congress sought to implement by broad preemption — and which this Court accomplished in *Pilot Life* — have been severely undermined by the decision of the court below. By permitting state law claims concerning alleged medically-based eligibility determinations, the Second Circuit has authorized the application of substantive state law to the administration of plans providing health care benefits. "[T]he significance of the holding by the Second Circuit cannot be overstated. . . . [I]ts protection of state law causes of action regarding medical practice and health care are monumental." Thomas A. Moore & Matthew Gaier, *Recent Second Circuit Decision on HMO Liability*, N.Y.L.J., Mar. 10, 2003, at 3. If applied everywhere, plan administrators would be required to make eligibility determinations under common law regimes that vary from one state to the next. The impact will be particularly acute on regional or national plans whose beneficiaries reside in different states. These plans will be subject to different and potentially conflicting liability laws, thereby "requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction" — exactly the result Congress sought to prevent through the enactment of § 514(a) and § 502(a). *Ingersoll-Rand Co.*, 498 U.S. at 142.

The disuniformity created by the Second Circuit's decision is compounded by the confusion that now exists in the lower courts regarding the impact of this Court's decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000) on state-law claims such as the one at issue here. Since *Pegram* was decided, at least seven federal circuit courts and two state courts of last resort have

addressed whether state law claims challenging alleged medically-based eligibility determinations are preempted by ERISA, and have handed-down conflicting decisions based on conflicting rationales. *See Land v. Cigna Healthcare of Florida*, __ F.3d __, No. 02-15549, 2003 WL 21751247 (11th Cir. July 30, 2003), *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003); *Haynes v. Prudential Health Care*, 313 F.3d 330 (5th Cir. 2002); *Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002), *petition for cert. filed*, 71 U.S.L.W. 3791 (U.S. June 3, 2003) (No. 02-1826), and *petition for cert. filed sub nom. Aetna Health Inc. v. Davila*, — U.S.L.W. — (U.S. June 20, 2003) (No. 02-1845); *Caffey v. Unum Life Ins. Co.*, 302 F.3d 576 (6th Cir. 2002); *Howard v. Coventry Health Care of Iowa, Inc.*, 293 F.3d 442 (8th Cir. 2002); *Pryzbowki v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001); *Villazon v. Prudential Health Care Plan, Inc.*, 843 So.2d 842 (Fla. 2003); *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001), *cert. denied sub nom. U.S. Healthcare Sys.of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 536 U.S. 938 (2002).

Thus, plan administrators must now divine not only the applicable federal law, but also the underlying state law in those jurisdictions that, like the Second Circuit, have subjected benefit decisions to state law causes of action. The difficulty of this task cannot be underestimated. Consider, for example, Pennsylvania, where the Third Circuit is at loggerheads with the Pennsylvania Supreme Court. In 2001, the Third Circuit held that ERISA preempts a state law claim for negligent delay in providing treatment, concluding that *Pegram* did not change the preemption analysis. *Pryzbowski*, 245 F.3d at 273. That same year, by contrast, the Pennsylvania Supreme Court invoked *Pegram* in holding that ERISA did not preempt a state law claim for medical malpractice where the benefit plan administrator makes a "mixed eligibility and treatment decision." *Pappas v. Asbel*, 768 A.2d at 1095-96. This situation has now become untenable for plan administrators in Pennsylvania. *See* Shannon P. Duffy & Randall J. Peach, *Split Decisions*, The Legal Intelligencer, April 6, 2001, at 1 ("What's a Pennsylvania lawyer

to do now that two of the highest courts in the land . . . have issued conflicting back-to-back opinions on the issue of when [a plan administrator] can be hit with a medical malpractice suit?").

Similarly, the court below was divided over the meaning of the dicta in *Pegram* that "mixed eligibility and treatment decisions" made by HMOs acting through their physician employees are not fiduciary acts within the meaning of ERISA. *Pegram*, 530 U.S. at 229. Seizing on that language, the majority held that if a state law malpractice action against an HMO is based on a "mixed eligibility and treatment decision," it is not subject to ERISA preemption so long as the state law cause of action involves allegations of faulty medical judgment. *Cicio*, 321 F.3d at 102. This was a significant misreading of *Pegram*, which was not a preemption ruling, as this Court itself recognized. 530 U.S. at 236-37. As Judge Calabresi's dissent points out:

> [*Pegram's*] well intentioned dicta can only make sense where the underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed a treating physician or such a physician's employer, as was the case in *Pegram*. Where, as here, no such relationship existed, there is no apparent reason, in state or federal law, for treating the unlawful coverage decision any differently from any other unlawful coverage that is not based on medical error.

Cicio, 321 F.3d at 109 (Calabresi J., dissenting).

In sum, an employee benefit plan can no longer maintain a nationally uniform administration of employee benefit plans because in many states the plan administrators must now reference state law rules. This Court's immediate review is necessary to restore the stability and consistency in the law that Congress found necessary to encourage employers to offer health benefits to their employees.

II. THE DECISION BELOW RAISES IMMEDIATE PRACTICAL PROBLEMS FOR ADMINISTRATORS OF EMPLOYEE BENEFIT PLANS THAT WILL ULTIMATELY HARM PLAN PARTICIPANTS

The decision below creates real and immediate operational issues for multistate employee benefit plans that will ultimately harm plan participants. Requiring plan providers to design their programs in an environment of differing state standards will complicate the administration of plans and increase the cost of health care coverage. In response, many employers will have no alternative but to reduce coverage to plan participants. Likewise, permitting state law claims will result in increased lawsuits arising out of benefit determinations that will drive-up the cost of administering and providing health care coverage and further undermine employers' willingness to provide coverage voluntarily. As one commentator has noted:

> Removal of ERISA preemption and adoption of more state liability laws could lead to an environment where HMOs and managed care plans are defending a number of lawsuits against a number of different plaintiffs in a number of different states arising under a number of different types of causes of action. This is exactly the environment from which Congress was trying to protect employee benefit plans generally when it enacted ERISA in 1974.

See Matthew J. Binette, *Comment: Patients' Bill of Rights: Legislative Cure-All or Prescription for Disaster?*, 81 N.C.L. Rev. 653, 693-94 (2003).

Such practical problems are illustrated by the very type of procedure at issue in this case. Vytra denied coverage of the double cell stem transplant on the grounds that it was an experimental treatment and, as such, was excluded from coverage under the express terms of the insurance contract.

Cicio, 321 F.3d at 88. In essence, the employee benefit plan had determined that there was insufficient clinical research or experience demonstrating that the treatment was efficacious or even safe for patients. Prior to the decision below, Vytra's determination would have been the same regardless of the jurisdiction in which a plan beneficiary resided; it would not cover this type of procedure. Now, Vytra must consider a range of factors. It first must determine what the law is in the jurisdiction in which the employee resides. If the employee resides outside the Second Circuit — for example in New Jersey — Vytra then may be able to administer the plan as contracted. If the employee resides in New York, however, Vytra must consider the applicability of the underlying state law and the degree to which state law claims might exist.

The situation is further complicated by the difficulty of assessing the applicability of state law to experimental treatments or other new medical technology developments. In effect, a plan administrator must speculate as to how state law judges and juries will evaluate experimental treatments and new medical technology for which there will exist no precedent. No reliable standards exist for a plan administrator to gauge how state law will apply to such determinations.

This is especially problematic because medical professionals often make claims regarding the efficacy of unproven, risky therapies only to see such claims eventually disproven by clinical trials. Instructive, on this point, is *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003 (9th Cir. 1998), *cert denied*, 528 U.S. 870 (1999), which involved a state law claim against a plan administrator that denied as experimental autologous bone marrow transplant ("ABMT") procedures to treat a woman's breast cancer. The Ninth Circuit concluded that the state law claim was preempted by ERISA, notwithstanding that an oncologist had recommended ABMT procedures. *Id.* at 1005, 1007-08. Notably, clinical trials subsequently

demonstrated that ABMT does not confer any greater chance of survival than conventional therapy. Patricia C. Kuszler, *Financing Clinical Research and Experimental Therapies: Payment Due, But From Whom?*, 3 DePaul J. Health Care L. 441, 457-462 (2000) (recounting history of ABMT). By that time, as many as 30,000 women had received the treatment, at considerable risk to their health — in fact, the treatment carried a death rate as high as 7.4%. *Id.* at 460-61.

Further, requiring benefit plan administrators to apply varying statutes and common law definitions of "experimental treatments" — to the extent such definitions exist — will limit the flexibility now enjoyed by benefit plan administrators to tailor plans to meet employers' and employees' needs and budgets. It also may result in one state being able to dictate plan designs on a nationwide basis.

In any event, the decision below and the more general confusion of the law in this area forces plan administrators to treat similarly situated employees differently. Although most employee benefit plans seek to provide the same coverage to all similarly situated employees, plan administrators must now consider whether to allow some employees to receive certain treatments out of fear of litigation even though a similar employee in a different state is not allowed the very same treatment.

For example, the employee benefit plan at issue in this case had an exclusion for experimental treatments. Prior to the Second Circuit's decision, an employee benefit plan in the downstate New York region could apply that exclusion uniformly regardless of whether its employees lived in New York, New Jersey or Connecticut. Under the Second Circuit's decision, however, an employer will have to abide by a new set of rules, which are based on different state common law causes of action and different state standards as to what is appropriate medical care. Employers must therefore do precisely

what Congress sought to prevent: predict the legality of a proposed action by referring to varying state laws.

Employers subject to the Second Circuit's jurisdiction will likely respond in two ways — both harmful to employees. Some employers may discontinue health care coverage rather than face the uncertain rules, litigation and higher costs that now apply to coverage determinations. Other employers may increase employee contributions or restrict benefits to counter-balance the higher risks employers now face. *See* Milt Freudeinheim, *Employees Paying Ever-Bigger Share for Health Care*, N.Y. Times, September 10, 2003, at A1 (reporting on authoritative study showing that almost 2/3 of large employers with employer-sponsored health plans raised the amounts that employees are contributing to the cost of their health plans this year, and 79% say they will do so again in 2004); The Business Council of the State of New York, Compensation Data New York 2003 (2003) (survey of New York employers reflects that, in a 12-month period ending in April 2003, more than 1/3 of employers increased the employee portion of health insurance premiums, and nearly 1/3 increased deductible levels). In either case, the decision below will undermine Congress' goal of encouraging employer-sponsored health coverage.

Every day plan administrators must make benefits decisions. These decisions are now being made under a cloud of uncertainty and risk of second guessing by state judges and juries. The situation is unworkable for plan administrators and their inevitable reaction may well have profound and unintended consequences for beneficiaries. Accordingly, *Amici* respectfully request that the Court grant the petition for certiorari to reestablish clear guidance not only for lower courts, but also for the plan administrators now confronted with the uncertainty and disuniformity Congress sought to avoid.

CONCLUSION

The petition for certiorari should be granted.

Respectfully submitted,

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